MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11750 CERTIFICATE OF DEATH ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY MARYLAND ALLEGANY ALLEGANY b. CITY OR TOWN (If outside corporate limits. C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If gutside carparate limits, write RURAL and give nearest town) write RURAL and give negrest town) CUMBERLAND 3 DAYS CUMBER! AND e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS SACRED HEART HOSPITAL YES NO V 305 PULASKI ST 3. NAME OF Middle Last 4. DATE Month Day pove corbon DECEASED (Type or print) WAYNE ALDERTON DEATH IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED last birthday) Months WIDOWED DIVORCED 04-23-08 WHITE rem and in an 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during mast af working life, even if retired) INDUSTRY COUNTRY? CLERK SAVOY BOWLING CUMBERLAND, ALLEGAN' 11.S.A 13. FATHER'S NAME crematian, ar removal, attending phys CECIL ALDERTON TROUTMAN WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address (Yes, na, ar unknown) (If yes give war or dates af service) 214-05-7089 HOSPITAL RECORD 1B. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).) INTERVAL BETWEEN signed by the burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate cause (o). DUE TO stating the underlying cause be retained by the haspital or attending 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(d) NO certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (County) (State) Hour To.m. Nat While factory, street, affice bldg., etc.) ot wark at work 21. I certify that (1) (this hospital) attended the deceased from Planck 1967, and that deoth occurred at 1967, from couses and on the dote stated obave saw the deceased alive on TO FUNERAL DIRECTOR: 22g. SIGNATURE M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S director, po shauld be f NAME (Type) RIDGELEY. 5 POTOMAC STREET. 230. BURIAL CREMATION 23b DATE THEREO! (State) (County)

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17751

1. PLACE OF DEATH					ution: Residence befare admission)
a. COUNTY	ALLEGANY	MARYLAND	g. STATE MAR	YLAND b. col	ALLEGANY
b. CITY OR TOWN	(If autside carparate limits,	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If	autside carparate limits, write R	URAL and give nearest town)
write KUKAL or	STBURG	15 DAYS	FRO	STBURG, RT. 1	01.1
d. NAME OF HOSPI	ITAL OR INSTITUTION (If not in h	aspital, give street address)	d. STREET ADDRESS		e IS RESIDENCE
MIN	ERS HOSPITAL				YES NO K
3. NAME OF DECEASED	First	Middle	Last	OF	nth Day Year
(Type or print)	CEORCE		ALDRIDGE	DEATH SEPTE	
S. SEX	6. COLOR OR RACE 7. N	MARRIED NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years	Manths Days Haurs Min.
MALE	FF dt de adea ade about	IDOWED DIVORCED 1	MARCH 25, 1	last birthday) 72 yrs.	manas bays nauts milit.
10a. USUAL OCCUPATIO during most of warking ETTRED MA	ON (Give kind of work done of the even if retired) LINTENANCE	10b. KIND OF BUSINESS OR REFACTORY	11. BIRTHPLACE (Count MARYI	y & State, or fareign country) AND	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN		
GEORGE L	ALDRIDGE		AMA	NDA E. REED	
15. WAS DECEASED EV	ER IN U.S. ARMED FORCES? (If yes give war ar dates af serv	16. SOCIAL SECURITY NO. 17.	INFORMANT		ress BOX 244
(163, na, ar anknawn)	for her dise was as galer as res	215-12-2367 MAJ	RIE S. ALDR	IDGE, RT1, FRO	OSTBURG, MD.
18. CAUSE OF I	DEATH (Enter anly one cause per ATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	r line for (a), (b), and (c).)	4 TRigues	fosis	INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER S	SIGNIFICANT CONDITIONS CONTRI	BUTING TO DEATH BUT NOT RELATED TO			19. WAS AUTOPSY PERFORMED?
ATIO	ald Mines	of Puliusway	monfile	cione ille to	YES NO N
S OR CONTRIBUTING	AS UNDERLYING G CAUSE OF DEATH Y MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED.			
20c. TIME OF IN	JURY Manth, Day, Year	20d. INJURY OCCURRED 20e. PLA	CE OF INJURY (Hame, fai	rm; 20f. (City ar tawn)	-(County) (State)
Haur a	.m. 19	While at wark at wark	tary, street, affice bldg., et	c]	
21. I cert	ify that (I) (this hospital	attended the deceased fram	dill.	19.4. to -//2	. 1967, that (1) (we) las
saw the c	deceased alive an	7/2 19/2 and tha	t death accurred a	t .Z. 26 M, fram causes	and on the date stated above
22a. SIGNATURE	1. 41	2011-	ATTENDING -	MED. STAFF	22b. DATE SIGNED
	Murrilly	Lett it East M.		MED. DIRECTOR PHYS.	11201
22c. PHYSICIAN' NAME (Type		ROTHSTEIN, M. D.	22d. ADDRESS 48 BRC	ADWAY, FROSTBI	JRG, MD.
23a. BURIAL, CREMAT	ION, 23b. DATE THEREOF	CREMATORY	23d. LOCATION (City or 1	awn) (Caunty) (State)	
BURIAL (Specif	SEPT. 4,	1967 FBG. MEMORIA	L PARK	FROSTBURG	G. MD.
24. FUNERAL DIRECT		ADDRESS	2Sa. REG		REGISTRAR'S SIGNATURE
JOSEPH	R. DURST. SR.	FROSTBURG. MD.	DATE	n 6 1967 2	Charles Judge :

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AND WEST TOTAL AT STEEL .

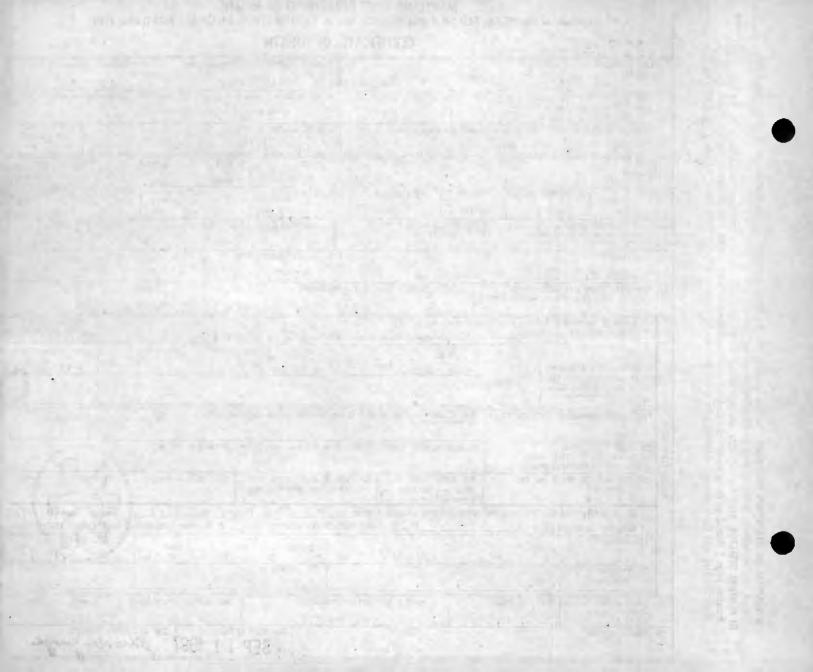
ADDRESS

CUMBERLAND, MD.

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VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17753 11740 -CERTIFICATE OF DEATH 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY ALLEGANY MARYLAND CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 PURGITTSVILLE **CUMBERLAND** d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? 50 MEMORIAL HOSPITAL NO TY YES law requires that the death certificate be executed within carban ent, wit 3 NAME OF Middle First 4 DATE ARNOL D SEPTEMBER DECEASED CORA (Type or print) DEATH 6. COLOR OR RACE
WHITE B. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED IF LINDER 24 HRS last bythday) FEMALE 6-10-1882 WIDOWFD DIVOR CED 11. BIRTHPLACE (County & State, or foreign country) 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of warking life, even if retired) INDUSTRY COUNTRY? USA W. VA. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remaya CABRIAL FEASTER CATHERINE MAY 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, or unknown) (If yes give war ar dates of service) MEMORIAL HOSPITAL, CUMBERLAND, MD. IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUF TO Conditions, if any, which gave (b) rise ta immediate cause (a), **DUF TO** stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? has med fo mod. since NO C certificate OR ATTENDING PHYSICIAN: 20o. ACCIDENT WAS UNDERLYING [3] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port | gr Part || gf item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year 20e, PLACE OF INJURY (Hame, form, (City or tawn) (County) (State) Haur 'a.m. foctory, street, office bldg., etc.) at work at work 21. I certify that (1) (this haspital) attended the deceased from 23 ang 1965, that (1) (we) last be retained 19 67, and that death occurred at 4:15M, Aran Couses and an the date stated above. TO FUNERAL DIRECTOR: saw the deceased alive an_ 22o. SIGNATURE 22b. DATE SIGNED STAFF PHYS. ATTENDING DIRECTOR M.D. PHYS. director, page should be filed 22c PHYSICIAN'S 22d. CUMBERLAND, MARYLAND NAME (Type) ORMER DATE THEREO BURIAL, CREMATION, ASB. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS 250. REC'D BY REGISTRAR VR A15 (4) 25M 1/67

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COMPANIAN CONTRACTOR

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11754 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) in by the funera O. COUNTYALLEGANY o. STATE b. COUNTY MARYL AND ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) papers. Pogr thin 72 hours of write RIPAL PUBER PETALNOWN 40 DAYS CUMBERLAND. MD. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? filled 411 CENTRAL AVENUE MEMORIAL HOSPITAL NO KX NAME OF pou First Middle completely I Last 4. DATE Month Year DECEASED EVA **ASHBY** SEPT. 19 MYRTLE 19 67 (Type or print) DEATH S. SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIEL NEVER MARRIED 8. DATE OF BIRTH lost big loy) Dovs Hours FEMALE COLORED 12-21-9 WIDOWED DIVORCED physicion and c in an 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? U.S.A. INDUSTRY puo ... VIRGINIA GENERAL MAID SERVICE WM. BTBRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal. ISAAC JOHNSON MARIA HICKMAN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO. Address (Yes, no. or unknown) (If yes give wor or dates of service CUMBERLAND. MD. MEMORIAL HOSPITAL crematian. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO signed Conditions, if ony, which gove rise to immediate couse (a). DHE TO stoting the underlying cause os the has been lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY for use Heolth (PERFORMED? this certificate 20o. ACCIDENT WAS LINDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) be retained by the hospital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. Not While factory, street, office bldg., etc.) 21. I certify that (1) (this hospital) attended the deceased fram and that death advired at: 30P FUNERAL DIRECTOR: saw the deceased alive and M. from causes an the date stated above 220. SIGNATURE ATTENDING M.D. PHYS -DIRECTOR PHYS director, poge should be filed 22d. ADDRESS 22c. PHYSICIAN'S O HOSPITAL NAME (Type) DR. B. SCHINDLER CUMBERLAND, MD. should 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Md. Cumberland Alleg 9/22/1967 Woodlawn Cemetery Burial 9 250. REC'D BY REGISTRAR DATE SEP 2 1 24. FUNERAL DIRECTOR ADDRESS REGISTRAR'S SIGNATURE, VR A15 (4) 25M 1/67 . Cumberlandbate Balto Ave 230

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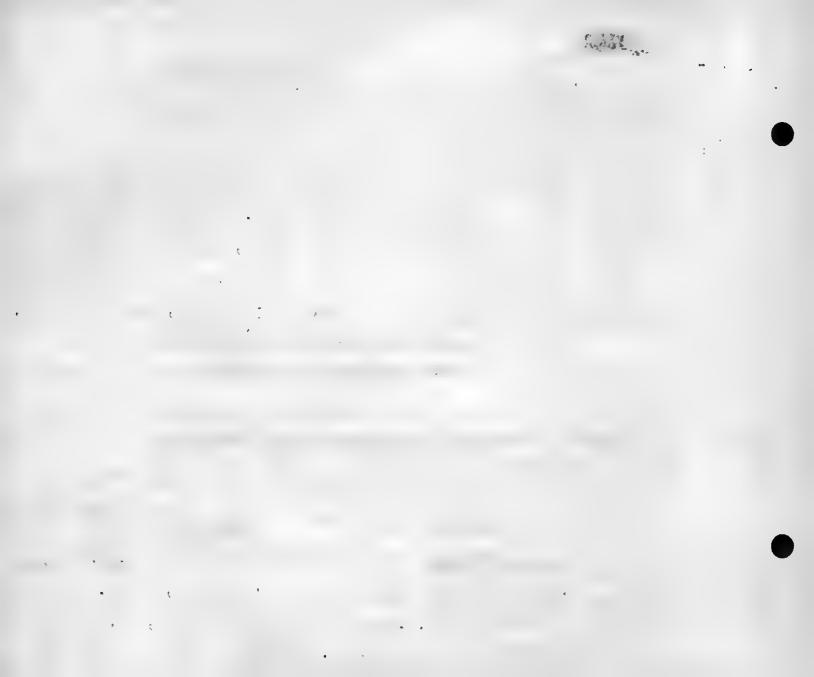
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1 1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND	21201
FOR STATE	1172 MARKET PARAMETERS OF PRATIC	11755
ENLTH DEM	1 PLACE OF DEATH a COUNTY Allegany MARYLAND 2 USUAL RESIDENCE (Where deceased wed, if institution Residence) a STATE Maryland	
s 1, 2, and 3 to srm PM3 Page Bepartment of urs after death.	b CIY OR TOWN (f autside carparate limits, write RURAL and give nearest town) Cumberland Cumberland	g ve nearest tawn)
te pages 1 and 2 with the State Depart in any event with the State Depart in any event with a 72 bours a	d NAME OF HOSPITA. OR INSTITUTION (If not in haspital, give street address) Memorial Hospital D.O.A.	e IS RES DENCE ON A FARM? YES NO
shauld be farwarded to the Chref Medical Exam ners Office along with files 3 should be used as = burial-transit permit. File pages land2 with the Statent, priar ta burial, cremation, or removal, and in any event with n 72 by	3 NAME OF First Middle Last 4 DATE Manth OF OF September (Type or point) Mildred Isabelle Beall DEATH September	Day Year 25 19 67
T N		DER 1 YEAR IF UNDER 24 HRS
any event	10a JSJAL OCCUPATION (G ve kind af work dane during most of working Life, even if retired) 10b KIND OF BUSINESS OR 11 BRTHPLACE (State or fareign country) 12	CITIZEN OF WHAT COUNTRY?
rile pages I and in any e	Frank Westcott Lottie Henderso	n
		oute #3 mberland.Md
as = burial-transit permit.	18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSTON DUE TO Cand't ans, if any, which gave rise to immediate cause (a), stating the underlying cause last [ast] (b) DUE TO (c)	INTERVAL BETWEEN OUSE AND GEATH SUDDEN
poula poula	PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19 WAS AUTOPSY PERFORMED? YES NO
priar	20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port II of Hem 18.) PRIMARY II or CONTRIBUTING II CAUSE OF DEATH.	
, i	Hour a.m. p.m. 19 While at wark at wark tactory, street, affice bldg., etc.)	(County) (State)
r its designated agent, priar ta	21. I certify that I took charge of the remains described above, held an Autopsy , Inspectiar X Inquiry death resulted from Natural causes X, Accident , Suicide , Hamicide , Undetermined mannul CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER SEPT.	3 (1
TO FUNERAL DIRECTOR: P	NAME (Type) BENEDICT SKITARELIC, M.D. Address (Street, city, town, or (Apply)) 238 B-RIAL, (REMATION) 238 DATE THEREOF 236 NAME OF CEMETERY OR (REMATORY) 230 LOCATION (City or Town)	MARYT.AND (Caunty) (State)
	Buriar 9/28/67 Sunset Nemorial Park Cumberland Alle 24 FUNERAL DIRECTOR H. Lee Silcox Cumberland, Laryland 21502 DATE Cumberland Alle 250 PK D By REGISTRAR 367 250 PK D By REGISTRAR 367 250 PK D By REGISTRAR 367 ADDRESS DATE	S SIGNAT 19E

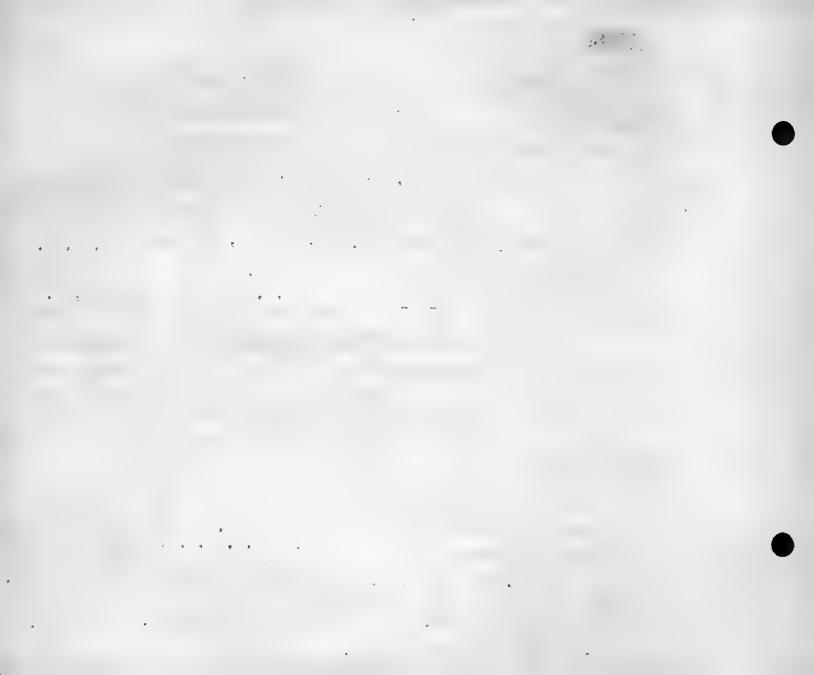
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11748 CERTIFICATE OF DEATH 11756 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceosed lived, if institut an Residence before admission) PLACE OF DEATH the attending physician and completely filled in by the funeral sit permit. Then please remays carban papers. Pages 1 and mation, at removal, and in any event, Within 72 hours after deap b. Allegany o. COUNTY Maryland Allegany MARYLAND c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) CLENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural Midland) Gilmore Frostburg e IS RES DENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitor, give street oddress) d. STREET ADDRESS Miners Hospital YES NO X Middle 4. DATE 3 NAME OF First Lost Year DECEASED 1967 BEEMAN H CHARLES DEATH 19 (Type or print) IF UNDER 24 HRS 8 DATE OF BIRTH S SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthday) Months Hours Male White WIDOWED X July 17th. DIVORCED 10o. USUAL OCC...PATION (Give kind of work done during most of working life, even if retired) 12 CITIZEN OF WHAT 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) COUNTRY? **INDUSTRY** Gilmore, Md. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Mary Green Andrew Beeman 17 INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16, SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war or dates of service) Salisbury, Mrs. Dewey Shrover INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART 1. DEATH WAS CAUSED BY: ONSET AND DEATH burial-transit IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached far use as the shauld be filed with the State Dept. of Health priar to WAS AUTOPS) PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) NO 💟 Page 4 may be retained by the haspital ar 20b DESCRIBE HOW WIURY OCCURRED. (Enter noture of pagey in Port I or Port II of item 18.) 200, ACC DENT WAS JNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year Hour o.m. factory, street, office bldg., etc.) Not While ot work 3, 1962 that (I) (we) last 2]. I certify that (I) (this hospital) attended the deceased from Cicco 14 19 62, and that death accurred at 300 CM, from couses and on the date stated above. saw the deceased alive an_ 22b. DATE SIGNED 22o, SIGNATURE STAFF PHYS. ATTENDING DIRECTOR M.D. 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) A.Paige Strong Frostburg 23d. LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY (County) (Stote) 23b. DATE THEREOF 23o. BURIAL CREMATION REMOVAL (Specify)
Burial Midland, 9/6/1967 St. Josephs Cemetery Md. 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Lonaconing, Md. George Eichhorn



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11744 CERTIFICATE OF DEATH 11757 aw requires that the death certificate be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH Allegany o. COUNTY Allegany b. COUNTY Maryland MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) /1966 Cumberland signed by the attending physician and completely filled in by butial-tronsit permit. Then please remove carbon papers. P Cumberland d NAME OF HOSP TAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? 220 Greene Street Allegany County Infirmary NO A YES T 3. NAME OF First 4. DATE Month Doy Year DECEASED OF September Bender 67 Albert Richard 19 (Type or print) AGE (In years 6. COLOR OR RACE 7 MARRIED DATE OF BIRTH **NEVER MARRIED** Doys Months Hours 8/11/1877 Male Whi te WIDOWED 10c. JSUAL OCCUPATION (Give kind of work done during most of working life even if ret red)
Retired: Carpenter 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT and in Construction Co. Cumberland, Maryland COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Richard Bender Mary A. Gessner 17. INFORMANT. P.O. Box 599, Cumberland, Md. 2150 IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, of unknown) (If yes give wor or dotes of service) 217-10-691 Allegany County Infirmary records INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o) ONSET AND DEAT PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stoting the underlying couse Poge 4 may be retained by the hospital or attending lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISFASE CONDITION GIVEN IN PART 1(a) PERFORMED? CERTIFICATION NO F 20o. ACCIDENT WAS UNDERLYING [205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) 20c TIME OF INJURY Month, Day, Year Hour om foctory, street, office bldg., etc.) at work O FUNERAL DIRECTOR: After 66 to 19 6 (that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from sow the deceased alive on 9/12/1967 19 P. M, from causes and on the date stated above and that deoth occurred at DATE SIGNED 22o. SIGNATURI X DIRECTOR X PHYS. M.D Memorial Hospital, Cumberland, Md 22c. PHYSICIAN'S NAME (Type) Topper, M. D. director, 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b. DATE THEREOF (County) (Stote) 23o. BURIAL, CREMATION REMOVAL (Specify) 9/15/67 Cumberland, Allegany. Peter & Paul Cemetery 24 FUNERAL DIRECTOR VR A15 (4) Cumberland, Md. H. Wayne George DATE 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11745 11758 CERTIFICATE OF DEATH low requires that the deoth certificate be executed within 24 hours after death. signed by the ottending physician ond completely filled in by the funerol burial-tronsit permit. Then pleose remove artism pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased leved, if institution: Residence before odm ssign) a. COUNTY g. STATE **b.** COUNTY ALLEGANY MARYLAND c LENGTH OF STAY IN 16 b CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) FROSTBURG FROSTBURG YEARS A NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? arban papers InterwithIn 72 h EAST MAIN NO Z MONERS MOS PTTAT 3 NAME OF First Middle East 4. DATE Manth Day Year DECEASED MAE SEPT 19 67 ANNA BENNETT (Type ar print) DEATH S SEX IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years last birthday) Months Dovs Hours FEMALE WIDOWED DIVORCED WHITE 10a USUAL OCCUPATION (Give kind of work dane during most of warking life, even if retired) 10b, KIND OF BUSINESS OR 11, 81RTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT INDUSTRY COUNTRY? HOUSEWIFE LONACONTNG OWN HOME 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME JOHN SEGGIE SARAH FOUTZ WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT MONACONING MD. (Yes are or unknown) (If yes give wor of dates of service CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if only, which gove rise to immediate couse (a), DUE TO for use as the t i Heolth prior to b stoting the underlying couse hos been lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 1865 YES NO this certificate 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour o.m. Not While factory, street, office bldg., etc.) O FUNERAL DIRECTOR: After be retoined by 21. I certify that (I) (this haspital) attended the deceased fram 1962, that (I) (we) last 19 6 7 and that death accurred at S. 40 MM, from causes and an the date stated above. saw the deceased alive an 22o, SIGNATURE 22b. DATE SIGNED ATTENDING MED. DIRECTOR M.D. PHYS PHYS. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) BROADWAY FROSTBURG director, should NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) REMOYAL (Specify) FROSTBURG FROSTRIBG 25b REGISTRAR'S SIGNATURE SOWERS HAFER-SOWERS VR A15 (4) 20 M 1/66 Ocharles 1967 HOME 60 W. MAIN FROSTRIRG

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11746 CERTIFICATE OF DEATH 11759 **OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAc and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DOA FROSTBURG CUMBERLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? 16 STANDISH STREET MEMORIAL HOSPITAL NO X NAME OF First Lost 4. DATE DECEASED SEPTEMBER BITTNER ROBERT FRANKLIN 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED **NEVER MARRIED** 8. DATE OF BIRTH AGE (n years last birthdoy) 7-10-1922 MALE WHITE WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working like COUNTRY? USA GOV. FROSTBURG. MD. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ZILPHA THOMAS J. BITTNER LOUIS 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO (Yes_no, or unknown) (If yes give war or dates of service MEMORIAL HOSPITAL, CUMBERLAND, MD. Yes 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) DUE TO Conditions, if any, which gave nse to immediate couse (o), DUE TO stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPS' PERFORMED? NO 7 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour om. factory, street, office bldg , etc.) 21. I certify that (I) (this hospital) attended the deceased fram 7 80m , 1962, that (I) (we) last saw the deceased alive an 14 20ml. 19 67, and that death occurred of 1:28, them Muses and an the date stated above. TO FUNERAL DIRECTOR: 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** MED DIRECTOR M.D. director, poge should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 122 S. CENTRE ST., CUMBERLAND, MD ORMER 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) BURIAL, CREMATION EMOYAL (Specify) 250. REC'D BY REGISTRAR 2Sb. RÉGISTRA SOWERS HAFER-SOWERS W. MAIN FROSTBURGATE SEP



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11760 The law requires that the death certificate be executed within 24 haurs after death by the funeral Pages 1 and 2 ours after death 2 USUAL RESIDENCE (Where deceosed lived, if institution. Residence before odmission) PLACE OF DEATH VIRGINIA o. COUNTY b. COUNTY MINERAL ALLEGANY MARYLAND c CITY OR TOWN (If outside corparate l'mits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate imits, CLENGTH OF STAY IN 16 PIEDMONT 30 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? filled i 46 PAXTON STREET HOSPITAL MEMORIAL YES NO X NAME OF Middle 4. DATE Month Yeor First Lost DECEASED ALBERT Η. BLAND remaye carb SEP1 DEATH (Type or print) S SEX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH 9. AGE (In years IF JNDER 24 HRS NEVER MARRIED 8 st birthdoy) Months Hours -17-1885 WHITE MALE WIDOWED crematian, ar remayal, and in any DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done COUNTRY? during most of working life, even if retired) Coa physician W. WARREN. W. VA. Mine Retired Miner 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME SARAH A. MYERS OLIVER BLAND INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO CUMBERLAND, MD. MEMORIAL (Yes, no, or unknown) If If yes give wor or dates of service INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (e), (b). signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by 4000 DUE TO Canditians, if any, which gove rise to immediate couse (o), DUE TO as the stating the underlying couse PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBULING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS PERFORMED? NO PHYSICIAN: 20b. DESCRIBE HOW INJURY OCCURRED tenter nature of injury in Port 1 or Part 11.65 stem 18 200 ACC DENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc.) Not While of work ot work 21. I certify that (I) (this haspital) attended the deceased fram. that (I) (we) last fram causes and an the date stated abave. 1967, and that death occurred at saw the accepted alive an... 220 SIGNATURE 22b. DATE SIGNED directar, page 3 shauld be filed v DIRECTOR 22d. ADDRESS 22 PHYSICIAN 2 NAME (Type) GREENE ST .. CUMBERLAND. MD. DR. W. G. WEISMAN 23d LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF (County) (Stote) 23o. BURIAL, CREMATION, REMOVAL (Specify)
Burial 9/18/1967 Oak Hill Cemetery Md. Lonaconing 0 ADDRESS 250 REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR DATESEP George Eichhorn Lonaconing, Md.



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11748 11761 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEP I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, it institution; Residence before admission) o. COUNTY delay is and 3 to o. STATE b. COUNTY Allegany Allegany MARYLAND Maryland b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If pels de carparate limits, write RURAL and give nearest tawn) 2, and PM3 F write RURAL and give nearest town) 40 years Cumberland Cumberland d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? State 3 Race Street 3 Race Street YES NO **X** 24 haurs after death NAME OF Middle First Lost 4. DATE Month Dov Year DECEASED (Type or print) ward "pending" in pencil in Item 18. Giv≡ the Chief Medical Examiner's Office alang Bloss DEATH Sept. John 1967 Carl gupto with S SEX 9 AGE (n years F UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED XX NEVER MARRIED 8 DATE OF BIRTH 5 ast birthdoy) Months Hours Male White Feb. 10.1908 -transit permit. File pages land 2 w event with:n 72 haurs after death. WIDOWED DIVORCED 1) BIRTHPLACE (State or Toreign country) 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IDB KIND OF BUSINESS OR 12 CITIZEN OF WHAT INDUSTRY COUNTRY? Railroad USA Seibert, Md. Trackman 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME This certificate should be executed within John Michael Bloss File Maude Twigg 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
[Yes, no, or unknown] (If yes give wor or dotes of service) 17 INFORMANT 16. SOCIAL SECURITY NO Address Mrs. Eugene Pendergast, Cumberland, Md. War II ves INTERVAL BETWEEN IB CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY StottenDEATH Coronary Occlusion IMMEDIATE CAUSE (o) 420 writing the ward DUE TO any Coronary Sclerosis Conditions, if ony, which gave (b) 0 rise to immediate couse (a), ⊆ DUE TO stoting the underlying couse and forwarded removal, PART II OTHER'S CHIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS AUTOPSY PERFORMED? please execute the certificate, NO 🕮 200. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 3 should PRIMARY I or CONTRIBUTING I Ö 4 should CAUSE OF DEATH 20c TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, larm, 20f (City or fown) (County) Hour am While Not While of work foctory, street, office bldg., etc.) may be retained far yaur FUNERAL DIRECTOR: Page 21 I certify that I taak charge of the remains described above, held an Autopsy , Inspection [32] Inquiry X ond in my opinion death resulted from: Noturo couses 3 Accident Suicide Hamicide Undetermined manner funeral directar. CHIEF MEDICAL EXAMINER ACTUAL 9-29-67 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER pror SIGNATURE S TO DEPUTY DEPUTY MEDICAL EXAMINER IX Rt. 9 Cumberland NAME (Type) Dr. Benedict Skitarelic, M.D. Address (Street, city, town, or county) 230 BURIAL CREMATION. 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 0 REMOVAL (Spec by)
Burial Oct.2.1967 Davis Memorial Cemetery Cumberland Md. Allegany 25h REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR 250 REC'D BY REGISTRAR 1967 VR A15ME (5) James F. Scarpelli, Cumberland.Md. 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH



0	-1 1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESION STREET, BALTIMORE, MARYLAND 21201
1		DIVISION OF VITAL RECORDS, 301 W. PRESION STREET, BALTIMORE, MARYLAND 21201 11749 CERTIFICATE OF DEATH
		PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) o. COUNTY ALLEGANY MARYLAND D. COUNTY MARYLAND MARYLAND ALLEGANY
_	hin 24 haurs after death filled in by the funeral Propers Pages I and thin 72 hours after deapt	b CITY OR TOWN (If outside corporate limits, write BURN ER EVANITY STARKLAND C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) I MONTH 5DAY S LONSONY Cumberland
	in 24 ho filled in hin 72 hi	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) SACRED HEART HOSPITAL d. STREET ADDRESS FOR Cumberland Hotel of RESIDENCE ON A FARM YES NO C
	letely fi	3. NAME OF First Middle Lost 4. DATE Month Doy Year 67 DECEASED (Type or print) LENA N BOHON SEPTEMBER 13 19
	t the death certificate be executed with the attending physician and campletely sit permit. Then please remove, cream nation, ar removal, and in any events with with	S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 8. DATE OF BIRTH 19. AGE (In years lost birthdoy) WIDOWED DIVORCED DEC. 13, 1897 (1897) 18. Days Hours Min
	ate be	100 USUAL OCCUPATION (Give kind of work done during most of solve) 100 KIND OF BUSINESS OR TUCKER, W.VA. 11 BIRTHPLACE (Country & Stote, or foreign country) 12 CITIZEN OF WHAT COUNTRY? U.S.A.
	certifica g physi Then pl moval,	13. FATHER'S NAME WILLIAM BOHON 14. MOTHER'S MAIDEN NAME OLIVE JEANETTE
death tending irmit. I		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no North Nown) (If yes give wor or dates of service) 16. SOCIAL SECURITY NO. 2 16-22-6076 17. INFORMANT Address 900 SETON DRIVE,
	that the death certificate be execan. by the attending physician and contransit permit. Then please remocrematian, ar removal, and in any	18 CAUSE OF DEATH (Enter only one couse per line fag(o), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) Lymphocifu Lenklennia IMMEDIATE CAUSE (o) DUE TO
	OR ATTENDING PHYSICIAN: The law requires that the be retained by the haspital ar attending physician. DIRECTOR: After this certificate has been signed by the je 3 shauld be detached far use as the burial transit ped with the State Dept. at Health priar ta burial, crematic	Conditions, if ony, which gove (b)
	e law rec tending p as been s as the b priar ta b	stating the underlying couse (c)
	IAN: The law radions of ar attending ficate has been far use as the Health prior to	PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS AUTOPSY PERFORMED? YES NO
	Page 4 may be retained by the haspital ar attending To FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be defached far use as the shauld be filed with the State Dept. af Health priar ta	PERFORMED? YES NO CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PERFORMED? YES NO CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
	R ATTENDING PHYSIC retained by the haspii ECTOR: After this certii 3 shauld be defached with the State Dept. af	20c. TIME OF INJURY Month, Doy, Year Hour a.m. 19 20d INJURY OCCURRED While of work o
	OR ATTENDING be retained by the INRECTOR: After e 3 shauld be ded with the State	21. I certify that (I) (this haspital) attended the deceased fram 3-6-67, 19, ta 9-13, 19-57 that (I) (we) I saw the deceased alive an 9-13, 19-67, and that death accurred at M, fram causes and an the date stated about
	ALOR AT OR AT UP be retained by the retained shiftled with filed with	220. SIGNATURE & ATTENDING MED DIRECTOR STAFF 22b DATE SIGNED 4-14-67
	O HOSPITAL OR Page 4 may be O FUNERAL DIR director, page 3	22c. PHYSICIAN'S NAME (Type) DR, LEWIS BRINGS 22d. ADDRESS 57 GREENE STREET, CUMBERLAND, MD.
	Page To Fun	236. BUR AL CREMATION. REMOVAL (Specify) Sept. 15, 1967 Davis Memorial Cemetery Cumberland, "d. Allegany
	VR A15 (4) 25M 1/67	James F. Scarpelli, Cumberland, Md. 250. REC D BY REGISTRAR 250 REGISTRAR'S SIGNATURE 250. REC D BY R



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11763 11750 CERTIFICATE OF DEATH **OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 havrs after death and completely filled in by the funeral remove carban papers. Pages I and in any eyent, within 72 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) I. PLACE OF DEATH Allegany o. COUNTY b. COUNTY Alle gany o. STATE Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 18/67 Frostburg Cumberland d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? attending physician and completely filled sermit. Then please carban pape Allegany County Infirmary YES NO X NAME OF Middle Month Doy Year DECEASED (Type or print) OF DEATH Lucinda Scott Bond September 67 IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED 9. AGE (In years **NEVER MARRIED** last birthdoy) Dovs Hours White n any Female WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Housewife INDUSTRY Maryland 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, or remaval Adam Scott Jane Nichols 17 INFORMANT P.O. Box 599, Cumberland, Md. 2150; 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service Allegany County Infirmary records. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART | DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the burial-transit UNSET AND DEATH IMMEDIATE CAUSE to DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO stating the underlying couse this certificate has been PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPS) PERFORMED? NO 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part 11 of Hern 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJJRY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While 21. I certify that (I) (this haspital) attended the deceased from saw the deceased alive an 9/21/67 19, and the ____, that (I) (we) last TO HOSPITAL OR ATTEND Poge 4 may be retained and that death accurred at_ P. M. from causes and an the date stated above. 220. SIGNATURE STAFF X DIRECTOR M.D PHYSICIAN'S NAME (Type) George M. Simons. M. D. Memorial Hospital, Cumberland, Md. directar, 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION 23b DATE THEREOF 23d. LOCATION (City or Town) (County) REMOVAL (Specify)
BURIAL 9-27-67 FBG. MEMORIAL PARK FROSTBURG, MD. 9 JOD 7 256 REDISTRABLY 24. FUNERAL DIRECTOR ADDRESS VR A15 (4) JOSEPH R. DURST, SR., FROSTBURG, MD. 21532



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH signed by the ottending physician ond completely filled in by the funeral burial-tronsit permit. Then please remove corban papers, Pages 1 on a COUNTY o. STATE b. COUNTY Allegany Marvland Allegany MARYLAND b CITY OR TOWN (If outside carporate rimits, write RURAL and give nearest tawn) c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) r LENGTH OF STAY IN LIG Frostburg Lonaconing e IS RESIDENCE ON A FARM? d NAME OF HOSPITA, OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS Water Station YES NO THE Miners Hospital 3. NAME OF Middle Last 4 DATE Manth Day Year DECEASED Buskirk 67 September 19 Type or print DEATH James Dewey 8. DATE OF BIRTH AGE (In years IF UNDER 24 HRS S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED bythdoy) Months Dovs Hours 10/10/1898 White DIVORCED or removal, and in any WIDOWED Male 1Da. USUAL OCCUPATION (G.ve kind of work done during most of working life, even if refired)

Retired Minister 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? INDUSTRY Lonaconing Maryland 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME Laura Buskirk William Buskirk WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (if yes a ve wor or dates af service Mrs.Rose Buskirk Lonaconing. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) ONSET AND DEATH DUE TO Canditians, if ony, which gove (P) rise ta immediate couse (a), DUE TO stoting the underlying cause os the prior to l hos been last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REDAKED TO THE TERMINAL DISEASEL CONDITION GIVEN IN PART 1(0) NO O FUNERAL DIRECTOR: After this certificate Page 4 moy be retained by the hospital or ģ 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) 20o ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER! 204 INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Hour a.m. factory, street, affice bldg., etc.) at wark 2 9 196 7, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. director, page 3 should should be filed with the 19 6), and that death accurred at A M, fram causes and an the date stated above. saw the deceased alive an Son 220. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR STAFF PHYS. ATTENDING M.D 22d. ADDRESS 22c. PHYSICIAN'S LONACONING NAME (Type) plnous NAME OF CEMETERY OR CREMATORY 23g. BURIAL CREMATION. 23b DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Sunset Memorial Cumberland Md 9/22/1967 Park 2Sb. REGISTRAR'S SIGNATURE 2Sq. REC D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) IIO M 1/66 Lonaconing, Maryland. SFP George Eichhorn

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11752 11765 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. and death funeral 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY a. STATE b. COUNTY ALLEGANY MARYLAND papers. Pages 1 hin 72 hours after by the fi b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b c CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) CUMBERLAND FAIRHOPE 65 DAYS _= d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? RT. #1. MEMORIAL HOSPITAL NO Y YES NAME OF Middle First 4. DATE Day Year DECEASED GERTRUDE SEPTEMBER 1967 В. BUTLER (Type or print) DEATH IF JNDER 24 HRS 6 COLOR OR RACE B. DATE OF BIRTH 9. AGE (n years 7. MARRIED NEVER MARRIED last birthdoy) Hours 8-11-1889 FEMALE WHITE WIDOWED DIVORCED I Ga, USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physican a during most of working the even if retired) INDUSTRY COUNTRY? VIRGINIA USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remayal, JOSHUA CANTERBERRY ELIZA SHULTZ WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, pa, or unknown) (If yes give war ar dates af service) 206-40-7774 MEMORIAL HOSPITAL.CUMBERLAND.MD 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY. ONSET AND DEATH me senteri artery occlimen IMMEDIATE CAUSE (a) 4 201 DUE TO Canditions, if any, which gave rise to immediate cause (a), DUE TO stoting the underlying couse has been last PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) WAS ALTOPS Resource plus coronors NO [20g ACCIDENT WAS UNDERLYING [7] 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I at Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d IN.JRY OCCURRED 20e PLACE OF INJURY (Hame, form, (State) 20c TIME OF INJRY Manth, Day, Year (Crty or town) (County) Hour o.m. factory, street, office bldg, etc.) at work O FUNERAL DIRECTOR: After 20 21. 1 certify that (1) (this haspital) attended the deceased fram ta :40, film Wuses and an the date stated above. saw the deceased alive an. and that death accurred at 1 22b. DATE SIGNED 22a SIGNATA M.D 22d. ADDRESS 22c. PHYSICIAN'S O HOSPITAL NAME (Type) DR. WEISMAN CUMBERLAND MARYLAND 23b. DATE THEREOF 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION (County) (Stote) REMOVAL (Specify) Portage Ohio Ravenna Grandview Memorial 250 REC D BY REGISTRAR 24 FUNERAL DIRECTOR 2Sb REGISTRAR SIS GNATURE VR A15 (4) 25M 1/67 וסטו Harvey H. Zeigler, Hyndman, Pennsylvania



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11766 OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY b COUNTY MARYLAND ALLEGANY LEGANY MARYLAND b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate limits, write RURAL and give negrest town) filled in by th papers. Paga hin 72 hours o write RURAL and give nearest town)
CUMBERLAND CUMBERLAND 12 DAYS d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS ON A FARM? completely filled MEMORIAL HOSPITAL NAME OF Year DECEASED SEPT. REBECCA 1967. CESSNA (Type or pnnt) DEATH ever JE LINDER 1 YEAR SEX 7. MARRIED 9. AGE (In years 6. COLOR OR RACE NEVER MARRIED Ligst birthdoy) 2. XXXXXXX FEMALE WHITE WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State or foreign country) during most of working life, even if retired)
HOUSEWIFE INDUSTRY MARYLAND OWN HOME 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal, FRANK GOOSH BESSIE POWELL IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no of unknown) (If yes give war ar dates of service) Ь MEMORIAL HOSPITAL -CUMBERLAND, MD. NONE IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave (b) nse ta immediate cause (a), DUE TO stating the underlying couse (c) 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 20a ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Hame, form, 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (City or town) (County) Hour a.m. factory, street, office bldg . etc.) 2). I certify that (1) (this hospital) aftended the deceased from M, from tauses and on the date stated above and that death occurred of TO FUNERAL DIRECTOR: sow the deceased office 22a SIGNATURE 22b. DATE SIGNED STAFF SEPT. 25,1967 DIRECTOR director, poge 3 should be filed a 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) DR. W. ROYCE HODGES S. CENTRE ST.. CUMBERLAND, MD 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23g BURIAL, CREMATION, 23b. DATE THEREOF (County) REMOVAL (Specify) SUPPETER & TAUL CEMETERY CUMBERLAND, MD. 25g RECD BY REGISTRAR 25h REGISTRAR S SIGNATURE 24 FUNERAL DIRECTOR ADDRESS VR A15 (4) 25M 1/67 CUMBERLAND, MD. 1967



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11767 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. COUNTY a STATE b. COUNTY Allegany State Department of Maruland MARYLAND c (TY OR TOWN (If autside carparate limits, write RURAL and give nearest town) b CITY OR TOWN (If auts de carparate limits, CLENGTH OF STAY IN 16 write RURAL and give nearest town)
Cumberland 20 hrs. Cumberland. a NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? egg with form Memorial Hospital 648 Fayette St. in pencil in Item 18. Give Pages YES NO X This certificate should be executed within 24 hours after death NAME OF First Midd e DATE Month DECEASED Monford Clapp Sept. DEATH 6 COLOR OR RACE 8 DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR 7 MARRIED NEVER MARRIED lost birthdoy) White June 1. 1891 WIDOWED DIVORCED 10a USUA. OCC. PAT ON (Give kind af wark dane during most of working He, even if retired)

Ret. metal worker

13 FATHER'S NAME 10b KIND OF BUSINESS OR 11 B:RTHPLACE (State or fare gn country) 12 CITIZEN OF WHAT Celanese Fibres COUNTRY? cremation, ar removal, and in any event with n 72 hours ofter Greensboro, N. C.

14. MOTHER'S MAIDEN NAME forwarded to the Chief Medical Exominer's Jasper A. Clapp Anna Whitehead 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give war ar dates af service) 214-07-0490 Mrs. Ethel P. Clapp 648 Fayette St. Cumb. Md INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PINSEL AND DEATH PART I. DEATH WAS CAUSED BY CEREBRAL HEMORRHAGE IMMEDIATE CAUSE (o) writing the word DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, Tony, which gave rise ta immediate couse (a), DUE TO stating the underlying couse PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? NO X 20a EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 206 DESCRIBE HOW NURY OCCURRED (Enter nature of injury in Part or Part II of item 18) CAUSE OF DEATH 20c TIME OF N. URY Month Day, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home, form, (City or town) (County) (Stote) factory, street aftice b dg , etc) moy be retained for your FUNERAL DIRECTO■: Page 21. I certify that I took charge of the remains described above, held an Autapsy , Inspection X, Inquiry X, and in my opinion death resulted fram Natural causes X. Accident . Suicide . Hamic de Undetermined manner 9/27/67 22. DATE SIGNED CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER Cumberland, Md. Benedict Skitarelic, M.D. Address (Street city town, or county) NAME (Type) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION ("ity or Town) 23a BURIA CREMATION Hillcrest Burial Park Cumberland. 9/29/67 Allegany Md. 250 RECD BY REGISTRAR 24 FUNERAL DIRECTOR VR ATSME H. Wayne George Cumberland, Maryland Thanks Judge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

		11755	CERTIFICAT	E OF DEATH	11768			
/	0	PLACE OF DEATH O. COUNTY ALLEGANY	MARYLAND	o STATE MARYLAND	d, if institut on Residence before admission) b COUNTY ALLEGANY			
		b CITY OR TOWN (If outside corporate limits, write RURAL and give neares town)		CUMBERLAND				
	0	d NAME OF HOSPITAL OR INSTITUTION (if not in MEMORIAL)		d STREET ADDRESS KELLY BLVD	e IS RESIDENCE ON A FARM? YES NOT			
	- (NAME OF DECEASED (Type or pnnt) MURIEL	Middle R	- I - I - I - I - I - I - I - I - I - I	SEPTEMBER 21, 19 67			
		FEMALE WHITE	MARRIED NEVER MARRIED DIVORCED DIVORCED	B. DATE OF BIRTH 6-13-1893 9 AGE lost	(In page 1964) IF UNDER 1964 IF UNDER 24 HRS Min.			
	durn	USUAL OCCUPATION (Give kind of work done ing most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	MOOREFIELD, W. VA.	12 CITIZEN OF WHAT COUNTRY? USA			
		CHARLES E. RALSTON 14. MOTHER'S MAIDEN NAME I DA B. RALSTON MONGOLD						
	(Yes	15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. NO. 17 INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.						
		TB CAUSE OF DEATH (Enter only one couse p PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove nse to immediate couse (o),	FT 17.	in secondos	interval between onse any death onse any death of the services			
		stoting the underlying couse DUE 10 (c)	Chronic Vor	in Harma a	terinschoris 1400			
	CERT FICATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDIT ON GIVEN IN PART 1(a) 19 WAS AUTOPSY PER FORMED? YES NO						
		20c ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Yeor		(Enter noture of injury in Port L or Port I? of ACE OF NJURY (Home, form, 20f (City)				
	MEDICAL	or town) (County) (Stote)						
	, 19, that (1) (we) last makes and an the date stated above							
		220 SIGNATURE 220 SIGNATURE MED. STAFF 220 DATES SCHED PHYS DIRECTOR PHYS AND						
1		NAME (Type) DR. MILTENBERGER COMBERLAND, MARTEAND						
	F	BURIAL, CREMATION, REMOVAL (Specify) 9/23/19	6.7 Loom Cemete	ry Near	Augusta, (County) (Stote) Hampsh W.Va			
	24	Tobal J. Hafer Jr. 230 Balta Ave. Cumberlands EP 25 1967						

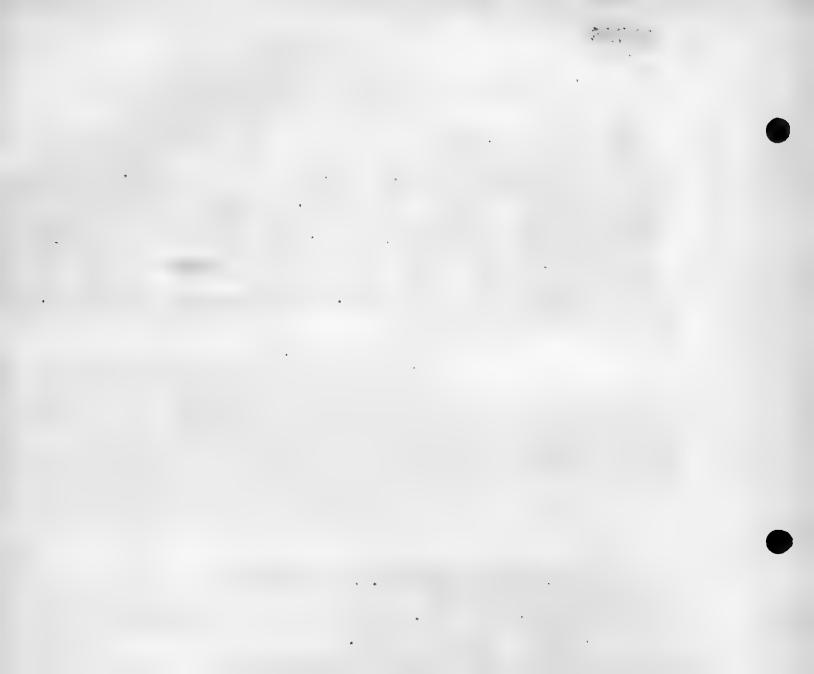
TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and director, page 3 should be detached far use as the burial-transit permit. Then please remashould be filed with the State Dept. of Health prior to burial, cremotian, or removal, and in any VR A15 (4) 25M 1/67

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

completely filled in by the funeral layer corbon papers. Pages 1 and 2 yevent, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 11769 and 2 death death. 1. PLACE OF DEATH
a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) b. COUNTY by the financial Pages 1 Allegany Maryland 24 hours after Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) completely filled in by tools carbon papers. Page Levent, within 72 hours a write RURAL and give nearest town) 50 years Cumberland Cumberland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 604 Louisiana Avenue 604 Louisiana Avenue No 3 death certificate be executed within NAME OF First Middle Month DECEASED (Type or print) Sept. Benjamin DEATH 20 19 67 Divico and con 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED last birthday) Months Days 1887 Male White WIDOWED X Sept. DIVORCED [10a, USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 2.5 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) been signed by the attending physician the burial-transit permit. Then pleased in to burial, cremation, or removal, and in 12. CITIZEN OF WHAT INDUSTRY COUNTRY? Cafe & Restaurant Self Employed Ceccano, Italy USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Paul A. Divico Anna M. Diana 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) , (If yes give war or dates of service) Mr. Joseph F. Divico, Cumberland, Md.Son yes War 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: be retained by the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO CLITTICA Conditions, If any, which tificate has been for use as the b f Kealth prior to b gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) CERTIFICATION PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY Page 4 may be retained by the hospital or a TO FUNERAL DIRECTOR: After this certificate director, page 3 should be detached for use should be filed with the State Dept. of Health PERFORMED? YES NO [20a. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part | or Part || of Item 18.) MEDICAL, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) (County) factory, street, office bldg., etc.) Hour a.m. Not While While OR ATTENDING at work at work 1967 to 5.5.4. 7. 0 196 / that (1) (we) last 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on ____M, from the causes and on the date stated above. and that death occurred at. 22a. SIGNATURE DATE SIGNED 22b. MED. DIRECTOR PHYS. PHYSICIAN'S NAME (Type) Virginia Aye., Cumberland, Md. Clay E. Durrett. M.D. BURIAL, CREMATION, REMOVAL (Specify) B urial 23a. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) SS. Peter & Paul Cemetery Cumberland, Md. Allegany 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS Scarpelli, Cumberland, Md. VR A15 (4) 15M 4-64



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11757 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEP PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. COUNTY Allegany P.M.3 Page Maruland MARYLAND b (ITY OR TOWN (if autside carparate l'mits, write RURAL ond give nearest town) Cumbertana c CITY OR TOWN (If autside carporate limits, write RURAL and give negrest town) C LENGTH OF STAY IN 15 pup Cresaptown. d NAME OF HOSPITAL OR INSTITLT ON (If not in hospital, give street address) d STREET ADDRESS D. O. A. Sacred Heart Hosp. Brant Rd. NO XX in item 18 Give Pages M ddle First Lost 4 DATE Month DECEASED William Dixon Josef Sept. 19 67 DEATH (Type or print) S SEX 6 COLOR OR RACE 8 DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF LINDER 24 HRS 7 MARRIED NEVER MARRIED lost birthday) Days Malo White Dec. 26. 1966 WIDOWED DIVORCED 12 CITIZEN OF WHAT 100 LSJAL OCCUPATION (Give kind of work done 10b K ND OF BUSINESS OR 11. BIRTHPLACE (State or fore.gn country) during most of working life, even if retired)
None, Infant

13 FATHER'S NAME NDUSTRY Fort Jackson. So. Carolina None. 14. MOTHER'S MAIDEN NAME Harold J. Dixon Gudrun Hofmann IS WAS DECEASED EVER IN US ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO This certificate should be executed (Yes, no, or unknown) (If yes give wor or dotes of service) ar remayal, None. Mr. Harold J. Dixon, Brant Rd. Cresaptown, Md 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c)) INTERVAL BETWEEN ONSET AND DEATH PART 1 DEATH WAS CAUSED BY Asphyxiation IMMEDIATE CAUSE (o) e, writing the ward farwarded to the Cl burial, cremation, DUE TO 11 Strangulation in Play Pen Conditions, if any, which gove nse to immediate couse (a), DUE TO stating the underlying couse PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? YES A NO 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port I of item 18) 200. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING Impinged on stroller pushed sidewamys in crib by CAUSE OF DEATH. (City or town) (County) 20c TIME OF INJURY Month, Day, Year 20d IN JRY OCCURRED 1 20e PLACE OF INJURY (Home, form, foctory, street, office b dg , etc) may be retained for your FUNERAL DIRECTOR: Page Cresaptown, Allegany, Md. 2:30 pm Sept. 3 Home 21 I certify that I taok charge of the remains described above, held an Autapsy [X], Inspection X, Inquiry X, and in my opinion deoth resulted fram-Notural causes ... Academ K.R. Suicide . Hamicide -Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATUR 5 may be 1 TO FUNERAL Health ar 1 DEPUTY MEDICAL EXAMINER X September 3, 1,67 BENEDICT SKITARELIC. M.D. Address (Street, city, town, or coun@hmberland, Maryland. 230 BURIAL, CREMAT ON 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF (County) (Stote) BULLAL (Specify) SS. Peter & Paul Cemetery Cumberland, Allegany. 9/6/67 24 FUNERAL DIRECTOR VR A15ME H. Wayne George Cumberland, Maryland DATESEP

6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 77771 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death physician and completely filled in by the funeral en blease remave carbon papers. Pages 1 and 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH b. COUNTY p. COUNTY a. STATE. ALLEGANY MARYI AND c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If guitside carparate limits, write RURAL and give negrest town) CITY OR TOWN (If outside carparate limits, WEEK FROSTBURG d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENC ON A FARM? MINERS HOSPITAL 163 MAPLE YES NO TY Middle DATE Year NAME OF First Last Day DECEASED NELLIE COLLINS ENGLE SEPT DEATH (Type or pant) 9. AGE (In years IELINDER I YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH last birthday) Months FEMALE WHITE AUG. 5. WIDOWED DIVORCED 90 100. USUAL OCCUPATION (Give kind of work done during most of working the even if retired) 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? BORDEN MINES. S 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME FRANCIS M. SKIDMORE JEANNETTE SLOAN 17. INFORMANT FRUSTBURG. IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. MD. (Yes, no, or unknown) (If yes give wor or dates of service) 220-52-9803 MRS. JAMES MC NEIL, JR., 1061 INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p ONSET AND DEATH Cerebral hemorrhage. IMMEDIATE CAUSE (a) DUE TO Hypertensive areriosclerotic vascular Conditions, if any, which gove rise ta immediate cause (a), DUE TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been as the last. WAS AUTOPSY PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? USB NO for 205, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20g ACCIDENT WAS UNDERLYING [1] OR CONTRIBUTING CIT CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) TIME OF INJURY Month, Day, Year factory, street, office bldg, etc.) at wark 21. I certify that (1) (this hespital) attended the deceased fram Sept 9, 1967, ta Sept 18, 1967, that (1) (see) last saw the deceased alive an Sept 18 1967, and that death accurred at 7:35 PM, fram causes and an the date stated above. 220. SIGNATURE 22b DATE SIGNED ATTENDING MED. DIRECTOR STAFF PHYS. M.D. director, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) J. WALTERS, M.D. BROADWAY. BURIAL, CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) FROSTBURG MARYLAND 25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11759 11772 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. 2. USUAL RESIDENCE (Where deceased lived, finishitation: Residence before admission) PLACE OF DEATH o. COUNTY b COUNTY **ALLEGANY** MARYLAND ALLEGANY MARYLAND. b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND. MD. 80 DAYS CUMBERLAND B IS RES DENCE ON A FARMA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS MEMORIAL HOSPITAL JANE FRAZIER VILLAGE NO P campletely fi NAME OF Middle First 4 DATE LOST **EVANS** SEPT. DECEASED BLANCHE OF DEATH (Type or print) 9 AGE (In years IF JNDER 1 YEAR 6. COLOR OR RACE 8. DATE OF BIRTH IF UNDER 24 HRS 7. MARRIED NEVER MARRIED lasters loy) Hours 8-6-82 FEMALE WHITE WIDOWED X DIVORCED 10b. KIND OF BUSINESS OR 10o USUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired)
HOUSEWIFE COUNTRY? U.S.A. INDUSTRY ALLEGANY -- MARYLAND 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME cremation, or removal, MARY ETTA DANIELS AARON STALLINGS 16. SOCIAL SECURITY NO 17. INFORMANT Address IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) CUMBERLAND, MEMORIAL HOSPITAL 220-52-9805 18. CAUSE OF DEATH (Enter on y one couse per line for (o), (b), and (c).)
PART L DEATH WAS CAUSED BY-INTERVAL BETWEEN IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse by the haspital or attending WAS AUTOPS) PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? be detached for use State Dept. of Health NO TO FUNERAL DIRECTOR: After this certificate 200, ACCIDENT WAS UNDERLYING I DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port 1 or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INTURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF NJURY Month, Day, Year Hour o.m. factory, street, office bldg., etc.) Not While at work 21. I certify that (1) (this haspital) attended the deceased fram_ , 19.6.7, that (1) (we) last UHR M, fram causes and on the date stated above. Page 4 may be retained and that death accurred at saw the deceased alive an. 22o. SIGNATURE 22b. DAJE \$IGNED. MED DIRECTOR STAFF PHYS. ATTENDING director, page 3 shauld be filed v MD PHYS ADDRESS CUMBERLAND, MD. 22d 22c. PHYSICIAN'S DR. NAME (Type) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) 230 BURIAL CREMATION. (County) REMOVAL (Specify) Md. Near Oldtown, Alleg 6/67 Stallings Cemetery Burial 250, REC D BY REGISTRAR 25b REGISTRAR S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS VR A15 (4) 25M 1/67 Balto Ave., Cumberland ond SEP distable 5



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11760 11773 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY b. COUNTY ALLEGANY MARYLAND VIRGINIA b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 15 t CITY OR TOWN (if outside corporate fimits, write RURAL and give nearest town) write RURAL and Caya page REAND WEEK **PETERSBURG** d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street oddress) d. STREET ADDRESS e IS RESIDENCE hin 72 i ON A FARM? MEMORIAL HOSPITAL 113 HIGHLAND **AVENUE** YES NO TY NAME OF Middle and completely f DATE Last Year DECEASED OF DEATH OLIE M. FEASTER (Type or pnnt) SEPTEMBER even SEX IF UNDER I YEAR 6 COLOR OR RACE DATE OF BIRTH 7. MARRIED **NEVER MARRIED** lost birthday) Months Days Hours MALE WHITE WIDOWED DIVORCED 1-18-1888 10o JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CIT ZEN OF WHAT 11 BIRTHPLACE (County & Stote or foreign country) during most of working life, even if retired) **INDUSTRY** COUNTRY? USA MAYSVILLE W. VA. RETIRED 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal, CHARLES FEASTER ANNIE GROVES 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service) MEMORIAL HOSPITAL, CUMBERLAND, MD. Yes 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the buriol-tronsit ONSET AND DEATH Conditions, if any, which gove) rise to immediate cause (a). DUE TO stating the underlying couse last. PART IS, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS , PERFORMED? 20a ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or fown) County (Stote) Hour o.m. Not While factory_street, offige bldg , etc) ot,work at work 21. I certify that (I) (this hospital) aftended the deceased fram and that death occurred at 5:00, flan Muses and on the date stated above TO FUNERAL DIRECTOR: saw the deceased give on 22d SIGNATURE DATESIGNED M.D. DIRECTOR PHYS 22d ABDRESS NAME (Type) R. J. WILLIAMS CUMBERLAND, MARYLAND director, should b 23c. BURIAL, CREMATION. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) ((ounty) REMOVAL (Specify) 9-9-67 Mt. Hebron Petersburg Grant V 24. FLNERAL DIRECTOR 25g. RECD BY REGISTRAR hm. Petersburg, W. Van SF VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH 11774 OR ATTENDING PHYSICIAN: The low requires that the deoth certificate be executed within 24 hours after deoth PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admiss on) O. COUNTILLEGANY b. COUNTAL LEGANY MARYLAND within 72 hours afte b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate I mits, write RURAL and give nearest town) WITTE CUMBERCAND MD. CUMBERLAND 10 MIN. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENC ON A FARM? MEMORIAL HOSPITAL, CUMBERLAND, MD. 415 SOUTH ST. NO X NAME OF Middle 4. DATE and completely freezove carbon First SEPTEMBER Year 7 DECEASED FRANZE **ERNEST** (Type or print) DEATH 5 SEX B DATE OF BIRTH 1920 IF LINDER 74 HRS 6. COLOR OR RACE AGE (In years IF UNDER 1 YEAR 7 MARRIED NEVER MARRIED lost (Lyiptoy) Hours DIVORCED K 10-22-1920 WHITE MALE puo 100 USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State or foreign (ou 'TY) 12 CITIZEN OF WHAT 10b KIND OF BUSINESS OR pleose during most of working life, even if retired) INDUSTRY II CONNTRX? MARYLAND_CIT e Ti Pailroad 13. EATHER S NAME 14. MOTHER'S MAIDEN NAME or removal, MONNINGO FRANZE (Domenico) KATHERYN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT HOSPITAL. CUMBERLAND, MD. (Yes, no, or unknown) (If yes give wor or dates of service MEMORIAL. War cremotion, 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c),) INTERVAL BETWEEN buriol-tronsit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) **O HOSPITAL OR ATTENDING PHYSICIAN:** The fow requires that Poge 4 may be retained by the hospital or attending physicion. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse os the prior to i WAS AUTOPSY PERFORMED? certificate has PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO 20g ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or fown) 20c. TIME OF INJURY Month, Day, Year (County) Hour 'o.m. factory, street, office bldg., etc.) at wark 21. I certify that (I) (this hospital) attended the deceased from Mr. Ram causes and and that death accurred at TO FUNITRAL DIRECTOR: saw the deceased aliveran an the date stated above. 22o, SIGNATURE MED DIRECTOR director, page 3 should be filed v 22c PHYSICIANS 22UMBERLAND, MD. WE I SMAN NAME (Type) 230 BUR AL, CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) ((ounty) REMOVAL (Specify) Patrick's C metery Currerland, Ed. Allegany 1967 256 REGISTRAR'S SIGNATUR 24. FUNERAL DIRECTOR **ADDRESS** 250. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 Cimilerland, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11775 11762 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY ALLEGANY OR ATTENDING PHYSICIAN: The law requires that the death tertificate be executed within 24 hours ofter MARYLAND b CITY OR TOWN (If autside corporate limits, write RURAL and give neorest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 10HRS. 25MIN IA VALE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS B IS RESIDENCE ON A FARM? HOSPITAL MEMORIAL NATIONAL HIGHWAY 3. NAME OF First Middle Last 4 DATE Month DECEASED OF DEATH HARDEN WILLIAM Harrison SEPTEMBER 19 67 (Type or print) S SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (n years IF UNDER 1 YEAR IF UNDER 24 HR 7. MARRIED XX **NEVER MARRIED** last burthday) WHITE MALE 2-27-1897 WIDOWED DIVORCED 10a JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CIT ZEN OF WHAT gramps of working life even if raticed COUNTRY? Office Manager
13. FATHER'S NAME JET.CO. HYNDMAN PA USA SAMUEL HARDEN SARA MILLER IS WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, ng, or unknown) (If yes give wor or dates of service) 16. SOCIAL SECURITY NO 17 INFORMANT Address MEMORIAL HOSPITAL. CUMBERLAND. MD. 214-07-1527 Unknown 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (d) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY ACUTE PULMONARY EDEMA IMMEDIATE CAUSE (a) DUE TO Conditions, if any which gove ARTERIOSCLEROTIC CARDIOVASCULAR DISERASE rise ta immediate cause (a), **D**UF TO stating the underlying couse WITHMARKED CORONARY INSUFFICIENCY PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS? NO X 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c FIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form (C ty or town) (County) (State) Hour a.m. factory, street, office bldg., etc.) at work to SEPT 21. I certify that (I) (this hospital) attended the deceased fram 1960 , 19 1967, that (I) (Xe) last 45 19 67, and that death occurred at 5:10 MMrom causes and on the date stated above TO FUNERAL DIRECTOR: saw the deceaselitative on 22g SIGNATURE 22b. DATE SIGNED M.D DIRECTOR PHYS PHYS director, poge should be filed 22c. PHYSICIAN'S ADDRESS NAME (Type) G.O. HIMMELWRIGHT VIRGINIA_AVE 23a BURIAL CREMATION 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) REMOVAL (Specify) 9/18/67 Sunset Memorial Park Cumberland, Allegany Md. 24. FUNERAL DIRECTOR ADDRESS 2Sa. REC'D BY REGISTRAR 25b. REG STRAR S SIGNATURE VR A15 (4) 25M 1/67 H. Wayne George Cumberland, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11762 CERTIFICATE OF DEATH 11776 death. death. . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o COUNTY o. STATE b. COUNTY Allegany Maryland Allegany MARYJAND b CITY OR TOWN (If outside carparate limits, write RURAL and give georest town) CLENGTH OF STAY IN 16 E. CITY OR TOWN (If outside corparate limits, write RURAs and give nearest town) pers. Pag 72 hours within 24 haurs 19 months LaVale d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS B IS RESIDENCE ON A FARM? Sylvan Retreat 608 N. 2nd Street NO PC YES NAME OF pan Middle 4 DATE First Last Manth Day Year DECEASED
(Type or pnnt) Elwood Walter Sept. 19 67 Henry and in any event, DEATH removercar dwo S SEX IF UNDER 24 HRS 6 COLOR OR RACE 8. DATE OF BIRTH 9. AGE in years IF UNDER 1 YEAR 7 MARRIED NEVER MARRIED last birthdov) May 6, 1894 Months Dovs Male White WIDOWED DIVORCED 18a TISUAL OCCUPATION (Give kind of work done Ē 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT requires that the death certificate be physician a during most of working life, even if retired) INDUSTRY U.S.A. Philadelphia, Co. Penna. Retire Dye House Forman Celanese Corp 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME ar removal, Walter Henry Ma Territ K. Krug the attending parties that the Wilhelmina 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give war ar dates of service Mrs. Dorothy Henry, 608 N. 2nd St. LaVale 217-104051 Yes crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: al-transit ONSET AND DEATH IMMEDIATE CAUSE (o þ DUE TO signed I bur al-tr burial, a Conditions, if any, which gave nse to immediate cause (a), DHE TO stating the underlying couse ed far use as the taffeether as the tage. O FUNERAL DIRECTOR: After this certificate has been Inst PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REVALED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? FICATION YES -NO 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18.) 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 2Ge. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Haur a.m. Nat While factory, street, affice bldg., etc.) of work at work April 15 19 67 to Sept. 29 19 67 that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased from... Sept. 28 19 67, and that death occurred at 8:30 Afrem causes and on the date stated above. saw the deceased alive on 220. SIGNATURE ATTENDING MED. DIRECTOR STAFF PHYS. director, page 3 M.D PHYS 22d. ADDRESS 22c. PHYSICIAN'S George Simons. NAME (Type) Memorial Hospital, Cumberland, Md. 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 2/67 Restlawn Memorial Gardens Near Cumberland, Alleg 255 REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTUR 2So. RECD BY REGISTRAR VR A15 (4 Ave., Cumberlane CT 3 1967 Marian 20 M 1/66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11764 Item #2d Film 11777 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAM: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) Allegany o COUNTY b. COUNTY Maryland Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
Cumberland 6/6/1967 Cumberland d. NAME OF HOSP TAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESSUM On Rescue Mise IS RESIDENC Allegany County Infirmary sion//Front/Street/3] NO IX 3. NAME OF Middle DECEASED (Type or print) OF DEATH Allen Hoover September S. SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 83 vrs Hours Male White 7/3**1/1**88µ WIDOWED X DIVORCED 10a. USUAL OCCUPATION (Give kind of work done IOB KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired) Employee. **INDUSTRY** COUNTRY crematian, or removal, and West Virginia 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Phoebe Simmons John Hoover IS. WAS DECEASED EVER IN ILS ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT P.O. Box 599, Cumberland, Md. (Yes, no, or unknown) ((If yes give war ar dates af service) 220-10-4062 Allegany County Infirmary records 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (d)
PART | DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSEL AND DEATH IMMEDIATE CAUSE (o) **DUE TO** Conditions, if ony, which gove nse to immediate cause (a), **DUE** TO stating the underlying couse Page 4 may be retained by the haspital ar attending certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINA. DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) (IF EITHER NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (City or town) (County) (State) Hour a.m. Not While factory, street, office bldg., etc.) at work 21. I certify that (1) (this haspital) attended the deceased fram 6/6. ta 9/12/19679 __, that (I) (we) last /196719 saw the deceased alive an 9/11 and that death accurred at ____A___M, from causes and an the date stated above. 22a. SIGNATURE 22b. DATE SIGNED STAFF PHYS. DIRECTOR X **D** 4 M.D 22c. PHYSICIAN 22d. ADDRESS FUNERAL NAME (Type) John Topper, M. D. Memorial Hospital Cumberland Md. 23d LOCATION (City or Town) 230 BURIAL CREMATION. 236. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County) REMOVAL (Specify) 2 Greenmount Cemetery Cumberland Allegany Maryland 250. RECD BY REGISTRAR 19070 REGISTRARS SIGNATURE Judge 24 FUNERAL DIRECTOR VR A15 (4) (25M 1/67 H. Lee Silcox Cumberland, Maryland 21502 DATE

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11765 CERTIFICATE OF DEATH 11778 The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased leved, if institution Residence before admission) n COUNTY o. STATE b. COUNTY ALLEGANY MARY, AND MARYLAND ALL EGANY papers. Pages b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1h. c. CITY OR TOWN (If outside carparate limits, write RURAL and give negrest town) write RURAL and give nearest town CUMBERLAND DAYS **CUMBERLAND** d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE thin 72 l ON A FARM? 411 AVIRETTE AVENUE SACRED HEART HOSPITAL YES NO X NAME OF Middle First 4 DATE Year Dov DECEASED HOPE SEPTEMBER venice ve (Type or print) ELI EN KELLEY DEATH 30 67 IF UNDER 1 YEAR S SEX FUNDER 24 HRS 6. COLOR OR RACE B DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED lost birthdoy) Months Days Hours and in any FEMALE WHITE WIDOWED DIVORCED 02~5~87 rem and 100 USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CIT ZEN OF WHAT during most of working life, even if retired)
TEXT I LE WORKER COUNTRY? ease INDUSTRY TEXTILE PLANT CUMBERLAND, MD. USA 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME cremation, or remayal, THOMAS KELLEY JUDY. CLARA 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) Janes ... Cumb. 17. INFORMANT 16. SOCIAL SECURITY NO Clarence Md214-07-4643 NO 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) burial-transit PART I, DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO signed a Turnlyon Conditions, if any, which gove rise to immediate couse (a), DHE TO stating the underlying couse Page 4 may be retained by the hospital or attending as the prior tal last WAS AUTOPS has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO certificate OR ATTENDING PHYSICIAN: 201 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 11 of item 18) 200 ACCIDENT WAS JINDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (City or town) (County) (State) Hour o.m. factory, street, affice bldg., etc.) Not While ol work at work , that (I) (we) last 21. I certify that (1) (this hospital) attended the deceased from and that death occurred a 405 AM, fram causes and an the date stoted above FUNERAL DIRECTOR: saw the deceased alive on 22o. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS. PHYS. DIRECTOR filed director, page ? 22d. ADDRESS 22c. PHYSICIAN S O HOSPITAL LEWIS BRINGS, M.D. GREENE ST., CUMB., MD. 21502 NAME (Type) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23o. BURIA, CREMATION 23d LOCATION (City or Town) (County) (Stote) Cumberland, Allegani, PSWOYAL (Specify) 10/3/67 Ma. Rose Hill Cemeteru 2 H. Wayne George 24. FUNERAL DIRECTOR **ADDRESS** 2So. RECD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) FUNERAL HOME 25M 1/67 DAR

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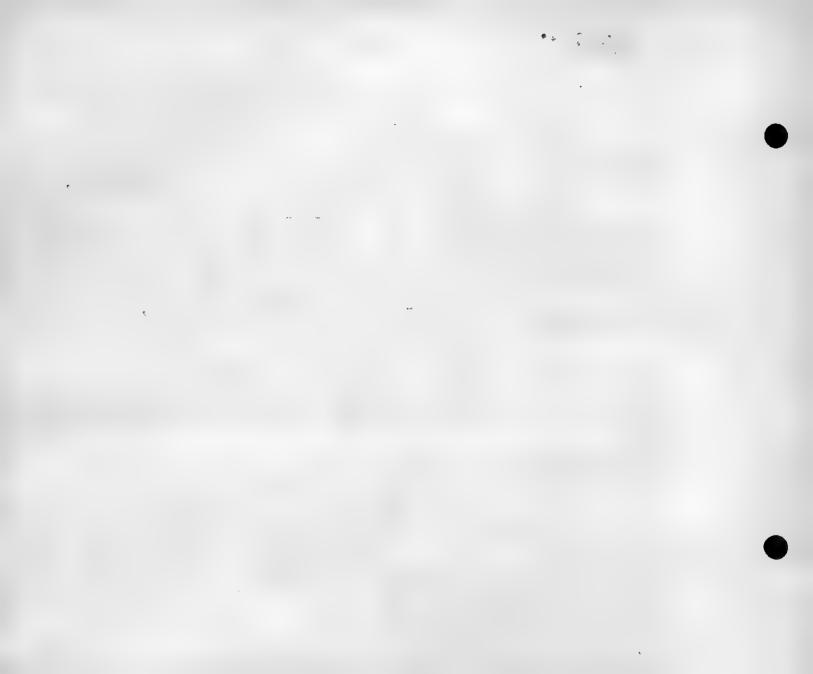
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11766 11779 CERTIFICATE OF DEATH ed in by the funeral apers. Pages 1 and 7 172 hours after deals. The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY a. STATE h COUNTY ALLEGANY MARYLAND MARY! AND ALLEGANY b CTTY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn)

CUMBERLAND c LENGTH OF STAY IN 36 c CITY OR TOWN (If outside carparate limits, write RURAL and give negrest town) **FROSTBURG** MONTH 2 DAYS filled in table d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 278 E. MAIN STREET Ę SACRED HEART HOSPITAL -900 SETON DRI YES NO 🔀 carban NAME OF First Middle 4. DATE Manth Last Day Year campletely DECEASED **FRANK KELLY** SEPTEMBER 19 19 67 (Type or pant) PATRICK DEATH E UNDER 1 YEAR SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9. AGE (In years I IF UNDER 24 HRS 7 MARRIED NEVER MARRIED remave cremation, ar remaval, and in any birthdov) Days Haurs 8-7-84 MALE WIDOWED DIVORCED WHITE and 100 USUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired)
TRAIL MAGISTRATE PEOPLES COURT U.S.A. physician SHAFT, MD. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME (BROGAN) PETER KELLY ANN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address permit. (Yes, no, ar unknown) (If yes give war or dates of service) 214-05-5399 HOSPITAL RECORD 900 SETON DRIVE, CUMBERLAND 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DEUNERAL DIRECTOR: After this certificate has been signed by **DUE TO** burial Uncertain Conditions, if any, which gave nse ta immediate cause (a). DUE TO stoting the underlying couse be detached far use as the State Dept. af Health priar to last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) WAS AUTOPSY PERFORMED? YES 📝 NO 200 ACCIDENT WAS JNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF IN. JRY Month, Day, Year Haur'a m. (City or fown) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (County) (State) factory, street, office bldg., etc.) Not While at work at work . 1967. to 21. I certify that (!) (this hospital) attended the deceased from 8-19 67, that (1) (we) last sow the deceased plive an and that death occurred at M, from couses and on the date stated above. 22b. DATE SIGNED 22a SIGNATURE STAFF alin directar, page 3 shauld be filed v M.D DIRECTOR 22c. PHYSICIAN S WASHINGTON & CUMBERLAND STREETS CALVIN HADIDIAN, M.D. NAME (Type) MD 21502 230 BUR AL CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) REMOVAL (Specify) FROSTRURG HAFERASO Martin 25M 1/67 HOME 60



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11767 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11780 FOR STANK HEALTH DEP 1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived if institution Residence before admission) o. COUNTY b. COUNTY MARYLAND ALLEGANY ALLEGANY MARYLAND c LENGTH OF STAY IN In b CTY OR TOWN (If outside corporate imits, c CITY OR TOWN (If outside carparate limits, write RURA» and give nearest town) write RURAL and give nearest town) 55 YRS. FROSTBURG d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, a ve street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? d "pending in pencil in Item 18 Give Pages 1, Chief Medical Examiner's Office along with farm hours MINERS HOSPITAL 115 BOWERY STREET YES NOX 3 NAME OF FIRST M-ddfe Lost 4 DATE Month 22 DECEASED ANNTE KENNEDY SEPT. 21, 19 67 (Type or pant) DEATH S SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9 AGE (In years FUNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED birthdovi JAN. 11, 1886 FEMALE WHITE WIDOWED DIVORCED tuewen 100 LSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 C TIZEN OF WHAT during most of working life, even if refired)
HOUSE WORK OWN HOME COUNTRY? MARYLAND be executed with n 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME ROBERT MOSES ANNA TUESDALE File IS WAS DECEASED EVER N . S ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address ar remayal. (Yes, no, or unknown) (If yes give wor or dotes of service) GEORGE KENNEDY, 107 GEORGE ST., FROSTBURG, MD 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY-Myocardial Failure IMMEDIATE CAUSE (o) This certificate should s a burial-tro crematian, DUE TO Conditions, if any, which gove Chronic Myocarditis rise to immediate cause (a). DUE TO stoting the underlying couse <u>Arteriosclerosis</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. D SEASE CONDITION GIVEN IN PART 1(0) 19 WAS ALTOPSY PERFORMED? Intertrochanteric Fracture of Right Femur NO X its designated agent, priar to 200 EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of Item 18.) 4 shauld Fell at home CAUSE OF DEATH 20d INJJRY OCCURRED 20e PLACE OF INJRY (Home, form, 20f (City or town) 20c TIME OF INJURY Month, Doy, Year (County) (State) factory, street, office bldg., etc.) 10:00AM Sept. 19 167 work Not While FUNERAL DIRECTOR: Page of work Frostburg, Alleg, Maryland 21. I certify that I took charge of the remains described above, held on Autopsy Inspection X, Inquiry X. ond in my opinion Accident X, Suicide , Homicide Undetermined monner deoth resulted from: Notural couses 1 CHIEF MED CAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATUR DEPUTY MEDICAL EXAMINER Ö Sept. 21, 1967 EXAMINER'S Health Address (Street, city, town, or county) RD 9. CUMBERLAND. MD. NAME (Type) BENEDICT SKITARELIC. M. D. 23d LOCATION (City or Town) (County) 230. BURIAL, CREMATION 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 500 REMOVAL (Specify)
BURTAL SEPT. 24 167 FBG. MEMORIAL PARK FROSTBURG, MD. **ADDRESS** 24. FUNERAL DIRECTOR VR A15ME JOSEPH R. DURST, SR., FROSTBURG, MD. 21532







MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY n. STATE **b.** COUNTY ALLEGANY MARYLAND b CITY OR TOWN (If autside corparate limits, CLENGTH OF STAY IN 16 c. CITY OR TOWN (If gutside carparate limits, write RURAL and give nearest town) write RURAL and give nearest town) R.F.D. 2 FROSTBURG LIFET d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) T. TREPTME filled in 1 IS RESIDENCE ON A FARM? d STREET ADDRESS (ZTHIMAN) ZIHLMAN NO T YES | NAME OF 4. DATE Middle Lost Manth Day physician and completely en please remove carbag First DECEASED ENNOX (Type or print) DEATH AGE (In years FUNDER S. SEX NEVER MARRIED DATE OF BIRTH 6 COLOR OR RACE 7 MARRIED Last birthday) Months Dovs Hours WIDOWED DIVORCED and in any 12. CITIZEN OF WHAT 10n USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 RIRTHPLACE (County & State or foreign country) COUNTRY? during most of working life, even if retired) INDUSTRY MARYLAND TIS. HOME ZIHLMAN 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME LYDIA ANN PORTER 17. INFORMANT IS. WAS DECEASED EVER IN ILS ARMED FORCES? 16 SOCIAL SECURITY NO. PRUSTBURG. MD. (Yes no, grunknown) (If yes give wor or dates of service) NO burial, crematian, INTERVAL BETWEEN IR. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c), burial-transit ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) signed by DHE TO Conditions, if ony, which gave rise to immediate cause (a). DUE TO stoting the underlying cause has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NiKE NO FX certificate 20g ACC DENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item, 18.) OR CONTRIBUTING [CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED. 20e PLACE OF INJURY (Home, form, (County) (State) 20c. TIME OF INJURY Manth, Day, Year, (City or town): O FUNERAL DIRECTOR: After this Hour a.m. factory, street office bldg., etc.) 21. I certify that (1) (this haspital) attended the deceased from. , 1966, to 4- SEFTT, 1967, that (1) (we) last director, page 3 shauld shauld be filed with the 7 1961, and that death occurred at 9.15 P.M. from causes and an the date stated above saw the deceased alive an 4 5 FPT 22b DATE SIGNED 22a. SIGNATURE PHYS. M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) BRLADE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) BURIAL, CREMATION 23b. DATE THEREOF (County) (State) REMOVAL (Specify) PARK FROSTBURG 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATUR SOWERS HAFER-SOWERS VR A15 (4) DATESE 20 M 1/66 YOUR HOME 60 W. MAIN FROSTBURG



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11785 11772 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be axecuted within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY a. STATE b. COUNTY MARYLAND ALLEGANY ALL EGANY b CITY OR TOWN (If outside corporate limits. C LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest tawn) ely filled in by the bon papers Page within 72 hours a write RURAL and give nearest town) CUMBERLAND MD. 1 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in haspitor, give street address) BARTON d STREET ADDRESS e IS RESIDENCE ON A FARM? MAIN STREET SACRED HEART HOSPITAL YES NO A NAME OF Middle remove corbon 4 DATE Month Day Year and completely DECEASED
(Type or pont) 19 67 LOGSDON 09 MARY 22 ent DEATH IF JINDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE B DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED rast burthday) Мол≢hs. Haurs 05-29-00 FEMALE WHITE WIDOWED X DIVORCED in any 10b KIND OF BUSINESS OR 100 JSUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT INDUSTRY puo ALLEGANY CTY, MD. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME removal ROSS Matilda Ross JOHN MARTIN BARRY IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na, or unknown) (If yes give war ar dates of service) 6 218-09-7820 HOSPITAL RECORD NO cremation, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY. ONSET AND DEATH IMMEDIATE CAUSE (a) signed t DUE TO Conditions, if only, which gave rise ta immediate cause (a), DUE TO r this certificate hos been si detached for use as the b te Dept. of Health prior to b stating the underlying couse by the hospital or attending last. PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? NO 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I at Part It of tem 3B.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm 20f (City or fown) (County) (State) Haur a.m. factory, street, affice blda., etc.) Not While of work of work . 19 ____ tø_____ , 19___, that (I) (we) last 21 I certify that (1) (this haspital) attended the deceased from_ be retained O FUNERAL DIRECTOR: saw the deceased alive an____ 19____, and that death accurred at M, fram causes and on the date stated above. 22g SIGNATURE 22b DATE SIGNED STAFF PHYS. terence . N. Vucceux M.D DIRECTOR PHYS 22d ADDRESS 22c PHYSICIAN'S NAME (Type) DR. CLARENCE J. VINCENT 126 N. SMALLWOOD ST. CUMBERLAND, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL (REMATION 23d LOCATION (City or Town) (Stote) St. Marys Lonaconing Md. 24 FUNERAL DIRECTOR
F. S. BOAL 25a REC'D BY REGISTRAR 25b REGISTRAR S SIGNATURE WESTERNPORT . MD.

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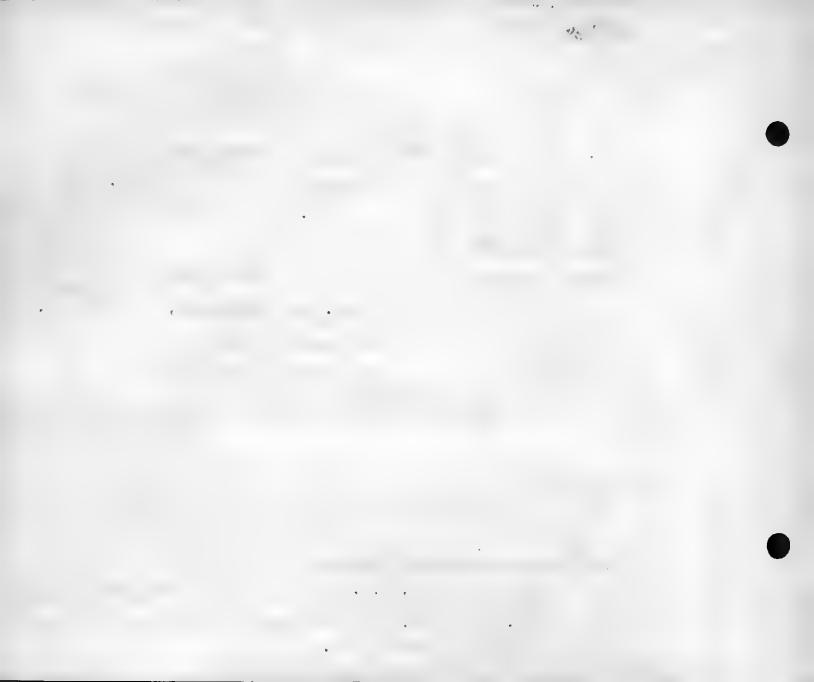
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11786 FOR STATI MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY Allegany 2, and Page o. COUNTY o. STATE Maryland Allegany MARYLAND state Department b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland CLENGTH OF STAY IN 16 c EITY OR TOWN (II autside corporate limits, write RURAL and give nearest town) Cumberland years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS along with farm ON A FARM? 34 South Street D. O. A. Memorial Hospital pencil in Item 18. Give Pages NO X This certificate shauld be executed within 24 hours after death. NAME OF Middle 4 DATE Month Dov Year DECEASED (Type or print) Malachowski Sept. 19 67 Μ. Peter DEATH 6 COLOR OR RACE 9 AGE (In years 7. MARRIED SK NEVER MARRIED B. DATE OF BIRTH IF UNDER 24 HR 68 lost birthday) Months Dec. 8, 1898 White Male DIVORCED the certificate, writing the ward "pending" in pencil in Item 1 4 shauld be farwarded to the Chief Medical Examiner's Office 100 .. SUAL OCCUPAT ON (Give kind of work done 11. BIRTHPLACE (Stote or foreign country) 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life even if retired)

Retired Boilermaker USA Poland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME within 72 haurs George Malachowski Jesse Woislaw 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service Mrs. Rose Malachowski, Cumberland, Md. 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I DEATH WAS CAUSED BY: INTERVAL BETWEEN event CORONARY OCCLUSION IMMEDIATE CAUSE (o) 4201 DUE TO any Conditions, if only, which gove to CORONARY SCLEBOSTS rise to immediate cause (a), DUE TO stating the underlying couse crematian, or remayal. PART II. OTHER S.GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPS PERFORMED? NO X 20o EXTERNAL CAUSE WAS 20b DESCRIBE MOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 1B.) 3 shauld PRIMARY I or CONTRIBUTING I CAUSE OF DEATH 20c T ME OF NJURY Month, Doy, Year 20d NJURY OCCURRED 20e PLACE OF INJURY (Home form 20f (City or town) (Stote) foctory, street, of lice bldg. etc.) of work ot work 21 I certify that I taok charge of the remains described above, held an Autopsy Inspection 😿 . Inquiry 🔽 and in my opinion death resulted from. Natural causes 🔽 . 🚄 ccident Suicide . Ham cide Undetermined manner funeral directar CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER may be re FUNERAL I DEPLTY MEDICAL EXAMINER NAME (Type) Benedict Skitarelic, M.D. Address (Street, city, town, or commberland, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL CREMATION, 23b DATE THEREOF Sept.19,1967 St. Mary's Cemetery Cumberland, Md. Allegany 24 FUNERAL DIRECTOR 250 REC'D BY REGISTRAR 2Sb. REGISTRAR S SIGNATURE Scarpelli, Cumberland, Md. 1967





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) & COUNTY ALLEGANY a COUNTY ALLEGANY o. STATE MARY LAND oon papers Pages I Within 72 hours often MARYLAND Pages b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 15 c CITY OR TOWN (If putside carparate limits, write RURAL and give nearest town) CUMBERLAND 5110. I I DYS CUMBERLAND d. STREET ADDRESS d NAME OF HOSP TAL OR INSTITUT ON (If not in haspital, give street address) complete styralled /F/9//B9X/599 216 Fulton St. CUMBERLAND MD. Carbon 3 NAME OF Middle 4 DATE Month First Year BELLE MARKS DECEASED OF DEATH 1067 event, (Type or print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. § SEX 8. DATE OF BIRTH 6. COLOR OR RACE 7 MARRIED NEVER MARRIED remove last_birthdoy) F W 6/12/1887 ond in any WIDOWED X DIVORCED 100 USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? pleose Own Home physician LONACONING. MD. 13 FATHER SHAW IFE 14. MOTHER'S MAIDEN NAME cremation, or removal, James Higgins Mary (Douglas 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service) INFORMANT 16. SOCIAL SECURITY NO. Mrs. Kenneth Grimes Cumberland, Md. None PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the c buriol-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) **O MOSFITAL OR ATTENDING PHYSICIAN:** The law requires the Poge 4 moy be retained by the hospitol or ottending physicion. DUE TO Conditions, if only, which gove rise to immediate cause (a), **DUE TO** stating the underlying couse 9 WAS AUTOPS' PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) be detached for use State Dept. of Health NO Z TO FUNERAL DIRECTOR: After this certificate 20g ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING [CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Hour a.m. Not While at work at wark 21. I certify that (I) (this haspital) attended the deceased from 1967, that (I) (we) lost director, page 3 should should be filed with the and that death occurred of 150 M sow the deceased alive an 58 from causes and on the date stated above. 22b. DATE SIGNED 22a SIGNATURE ATTENDING MED. DIRECTOR PHYS **ADDRESS** 22c PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23g BURIAL CREMATION. (State) REMOVAL (Specify) Burial Cumberland Hillcrest Burial 24. FUNERAL DIRECTOR 25g. REC'D BY REGISTRAR 256. REGISTRAR S SIGNATER DATE SEP VR A15 (4) 20 M 1/66 136 William G. Kight Cumberland, Md

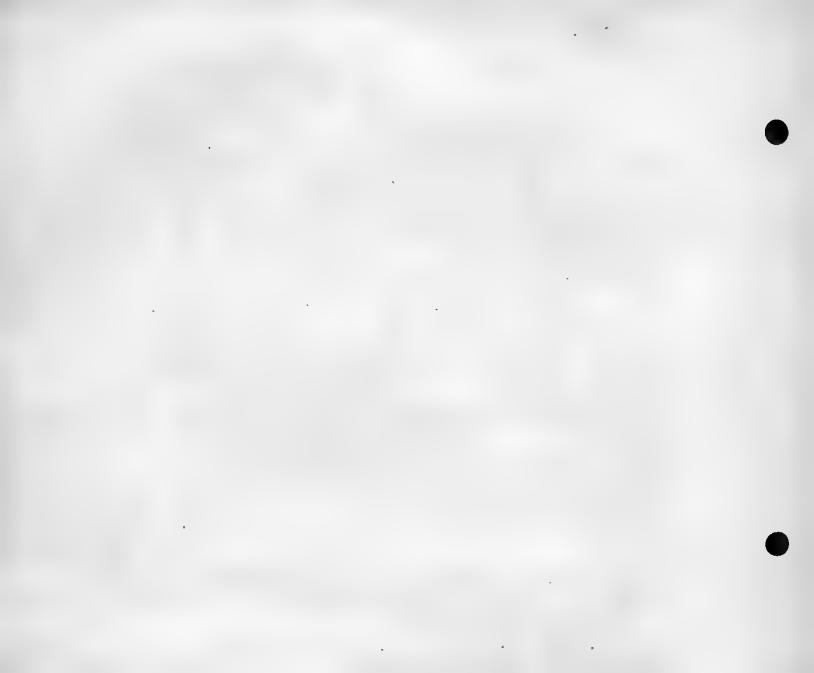


MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1	TIGGO		CERTIFICA	TE OF DEATH		11789			
	PLACE OF DEATH O. COUNTY			CTATE	2. USUAL RESIDENCE (Where deceased lived, if institution: o STATE MARYLAND b. COUNTY				
Ì	b. CITY OR TOWN (If outsid write RURAL and give n	e corporate limits,	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If or	uts de corporote limits, write RURA	L ond give nearest town)			
	write Konze and give it	CUMBERLA	ND YEARS	CUME	BERLAND RURA	L			
	d, NAME OF HOSPITAL OR II	,	tal, give street address) HOSPITAL	d. STREET ADDRESS BOX	503,RT#3,ROA	D e. IS RESIDENCE ON A FARM? YES NOX			
	3. NAME OF DECEASED (Type or print)	First CARL	Middle W .	Lost MARTIN	4. DATE Month OF DEATH SEPTE	Doy Year MBER 8. 19 67			
		OR OR RACE 7. MARK	[]	8. DATE OF BIRTH	face distributed	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
	10a. JSUAL OCCUPATION (Give k	and of work done	B. KIND OF BUSINESS OR INDUSTRY		& State, or foreign country) ND, MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA			
	13 FATHER S NAME			14. MOTHER'S MAIDEN	NAME				
ı		MARTIN		LILLIAN					
ı	15 WAS DECEASED EVER IN U.S. (Yes, no, or unknown) (If yes g		16. SOCIAL SECURITY NO	17. INFORMANT	Address				
ı	No		705-09-3405	MEMORIAL	HOSPITAL, CU	MBERLAND, MD.			
	PART I. DEATH WAS	nter only one couse per lin CAUSED BY. MMEDIATE CAUSE (o)	for (o), (b), and (c).)	tosis Ger	renralizar	INTERVAL BETWEEN ONSET AND DEATH			
ı	Cond tions, if ony, which	DUE TO	de Con	0	4, - 0	Not Know			
ı	rise to immediate couse	(0), ()	wens. au	inena	recont 9.	700776718000			
Į	lost.	(c)							
	PART II. OTHER SIGNIFICAL	NT CONDITIONS CONTRIBUT	ING TO DEATH BUT NOT RELATED	TO THE TERMINAL DISEASE CO.	NDITION GIVEN IN PART 1(0)	19 WAS AUTOPSY PERFORMED? YES NO			
	OR CONTRIBUTING CAUSE OF DEATH (I FITHER NOTIFY MEDICAL FRAMINER)								
	20c. TIME OF INJURY Manth, Day, Year Hour o.m. 20d. INJURY OCCURRED While of work of								
١		t (I) (this hospital) at d alive an 8550 kg	tended the deceased from		3:25M, Aran Maruses ar	, 19 <mark>6 _ (that (I) (we) lo</mark> nd an the date stated abov			
220. SIGNATURE ATTENDING MED. STAFF 226. DA Legen Director Phys Staff Staff									
	22c. PHYSICIAN'S NAME (Type) DF	R. WHITWOR	TH	22d COMBER	LAND, MARYLA	NO			
	230. BURIAL, CREMATION, REMOVAL (Sperity)	23b. DATE THEREOF Sept 11, 1	23c. NAME OF CEMETERY 967 Hillcrest	Burial Park	23d. LOCATION (City or Town Near Cumber 1				
	John J. Haf	er, Jr. 230	Bailo Ave., C	250. RECTUMBER LAND		STRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remaye carban papers. Pages—and should be filed with the State Dept. af Health prior to burial, cremation, ar removal, and in any event, within 72 hours affected the should be filed with the State Dept. af Health prior to burial, cremation, ar removal, and in any event, within 72 hours affected the second control of the second control Page 4 may be retained by the haspital or attending physician. VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11790 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) any delay is i, 2, and 3 ta n PM3. Page o COUNTY a. STATE b COUNTY the State Department of ALLEGANY MARYLAND MARYLAND ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If autside corporate imits, write RURAL and give nearest town) CLENGTH OF STAY IN 15 50 YEARS CUMBERT, AND CIIMBERT, AND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) e IS RESIDENCE ON A FARM? ang with form d. STREET ADDRESS MEMORIAL HOSPITAL 630 HILL TOP DRIVE YES NO IX This certificate shauld be executed within 24 hours after death NAME OF Inst 4 DATE Month Doy Year DECEASED OF DEATH HELEN SEPT. 26 (Type or print) V. MA THEWS IF UNDER 1 YEAR 6. COLOR OR RACE 8 DATE OF BIRTH AGE (In years IF UNDER 24 HRS 7. MARRIED NEVER MARRIED birthday) Manths Dovs Haurs in Item 18. DIVORCED AUG. 31,1881 WIDOWED FEMALE WHITTE 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? in any event within 72 haurs after HOUSEWIFE W. VA. the certificate, writing the ward "pending" in pencil in 4 shauld be farwarded to the Chief Medical Examiner's OWN HOME USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WILLIAM H. CHAPLINE IBA M. COOKUS IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT åddress burial-transit permit. (Yes, no, or unknown) (If yes give wor or dates of service 217 48 2305 MRS. ELIZABETH KONZAL CUMBERLAND. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I, DEATH WAS CAUSED BY: INTERVAL BETWEEN Occlusion Coronary IMMEDIATE CAUSE (a) DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause lost. be used remaval, PART I OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(d) 19 WAS AUTOPSY PERFORMED? NO 20a. EXTERNAL CAUSE WAS 20b DESCR BE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) 3 shauld I crematian, ar PRIMARY I or CONTRIBUTING I CAUSE OF DEATH MEDICAL 20c TIME OF INJURY Month Doy, Year 20d INJURY OCCURRED 2De PLACE OF INJURY (Hame, form 20f (City or town) (County) (Stote) Hour am. factory, street, affice blda, etc.) may be retained for your FUNERAL DIRECTOR: Page Not While of work of work 21. I certify that I taak charge of the remains described above, held on Autopsy nspection [X], Inquiry [X], and in my opinion the funeral directar. death resulted fram: Natural causes X. Accident . Suicide . Homicide . Undetermined manner CHIEF MEDICAL EXAMINER prior to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SEPT. 26,1967 DEPUTY MEDICAL EXAMINER (X) EXAMINER'S Address (Street, city, town, or county) Cumberland. Md. O FUNE Health BENEDICT SKITARELIC. M.D. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION, 23b DATE THEREOF 23d LOCATION (City or Town) REMOVAL (Specify) SHEPHERDSTOWN, W. VA. Y REGISTRAR 25b. REGISTRAR'S S GNATURE SEPT 28,1967 BURIAL ELMWOOD CEMETERY 24 FUNERAL DIRECTOR BYRON KIGHT ADDRESS 2Sq REC'D BY REGISTRAR VR A15ME (5) CUMBERLAND, MD. Ulliane DARCT 2 1962 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11791 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased rived, if institution Residence before admission a. COUNTY ALLEGANY PENNSYL VAN I Mithin 24 hours after MARYLANO c LENGTH OF STAY IN 16 b CITY OR TOWN (If autside corparate limits, c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) **BUFFALO MILLS** HRS. MIN. d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? RT. MEMORIAL HOSPITAL I BOX 73 YES AL NO 3 NAME OF MAYS JOHN Middle AY DATE Manth Day DECEASED SEPTEMBER complete event, (Type or print) DEATH OR ATTENDING PHYSICIAM: The law requires that the death certificate be executed S. SEX 6 COLOR OR RACE B DATE OF BIRTH IF UNCER 1 YEAR IF UNDER 24 HRS 7. MARRIED 9. AGE (in years NEVER MARRIEO last birthday) Haues MALE WHITE 4-27-1891 and in any WICOWEO DIVORCEO 10a. USUAL OCCUPATION (Give kind of wark dane during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT INQUSTRY PENNS YL VAN I A Farming 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME removal, GEORGE MAYS ANNIE SUDER 16. SOCIAL SECURITY NO 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? Address (Trapp, ar unknown) (If yes give war ar dates of service) Þ MEMORIAL HOSPITAL. CUMBERLAND, MD. crematian, 18 CAUSE OF DEATH (Enter only one cause per line for (a), NTERVAL BETWEEN PART I. DEATH WAS CAUSED BY. ONSET AND DEATH IMMEDIATE CAUSE (a) signed by Page 4 may be retained by the hospitat or attending physician. DUE TO 1das burial, Canditions, if any, which gave (b) rise ta ımmediate cause (a), ertificate has been s ed far use as the b of Health priar tab DUE TO stating the underlying cause PART 1. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA, D SEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? NO DE YES | O FUNERAL DIRECTOR; After this certificate 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 11 of Item 8) 20g ACCIDENT WAS JNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (State) Haur 'a m. factory, street, affice bldg., etc.) Not While at work at wark 21. I certify that (I) (this haspital) attended the deceased from 30 M, train causes and on the dote stated above. saw the deceased alive an. and that death accurred at 22a SIGNATURE 22b DATE SIGNED ATTENOING M.D. 22c PHYSICIAN'S 22d. ADDRESS DR. DROSS CUMBERLAND. MD. NAME (Type) 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, (County) PEMOVAL (Specify) Madley Cemetery 250 REC O BY REGISTRAR 3 SIGNA 24. FUNERAL DIRECTOR VR A15 (4) OATESEP H. Zeigler, Hyndman 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11792 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) o. COUNTY and 3 ta Page **5 COUNTY** Alle, any Maryland Alle, any MARYLAND delay if the State Department b CITY OR TOWN (if outside corporate mits, write RURAL and give regress fown)
Curreer Land c LENGTH OF STAY IN b c CITY OR IDWN (It outside corparate limits, write RURAL and give negrest town) P.M.3. 40 years Cumberland d NAME OF HOSPITAL OR INSTITUT DN (If not in hospital, give street oddress) d STREET ADDRESS e IS RES DENCE ON A EARM? Office along with farm This certificate shauld be executed within 24 haurs after death. If kate, writing the ward "panding" in pencil in Item 18. Give Pages 1, D. O. A. Memorial Hospital 120 West First St. YES NO-3 NAME OF Midd e 4 DATE Year Day DECEASED (Type or print) OF DEATH Mc Donald Edgar S. Sept. 1967 7 MARRIED IE UNDER 1 YEAR IF UNDER 24 HRS 6 COLDR OR RACE NEVER MARRIED 8 DATE OF BRITH 9 AGE (In years 4 lest b.rthdoy) Nov. 28, 1917 Months Hours in any event within 72 haurs after death. WIDOWED | White DIVDRCED Male 100 USUAL OCCUPATION (Give kind of work done II BIRTHPLACE (State or foreign country) 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY Textile **COUNTRY?** Ronney, W. Va. USA please execute the certificate, writing the ward "panding" in penul in director. Page 4 should be farwarded to the Chief Medical Examiner's 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Virgil Mc Donald Blanche Peer 15 WAS DECEASED EVER NUS ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service) 217-10-4389 Mrs. Esther Mc Donald, Cumberland, Md. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY NTERVAL BETWEEN ONSET AND DEATH CORONARY OCCLUSION IMMEDIATE CAUSE (o) DUE TO CUBUNIARY SCIEDOGIS Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(p) 9 WAS AUTOPS PERFORMED? NO A 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY DECURRED (Enter nature of injury in Part or Part 1 of Item 18.) 3 shauld PRIMARY I or CONTRIBUTING I Health priar to buriar, cremation, ar AL EXAMINER: CAUSÉ DE DEATH 20c TIME OF NouRY Month, Day, Year 20d NURY DCCURRED 20e PLACE OF NJURY 1 Home, form, 20f (Eity or town) (County) (State) factory, street, office bldg. etc 1 Not While FUNERAL DIRECTOR: Page While Not While of work 21. I certify that I taak charge of the remains described above, held on Autopsy Inspection XX Inquiry X, and in my apinion death resulted fram: Natural causes [X], Accident [Suicide], Hamicide [Undetermined manner CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASS STANT MED CAL EXAMINER SIGNATURE X DEPUTY MEDICAL EXAM.NER IN September 6, 1967 **EXAMINER'S** Penedict Shitarelic, h.D. Address (Street, city town or county Cumberl nd; Mi. NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d (CCATION City of Town) 230 BURIAL, CREMATION, 23b DATE THEREOF REMOVAL (Specify) Sept. 9, 1967 Hillcrest Burial Park Cumberland 11d All ADDRESS 250 RECOBY REGISTRAR'S SIGNATURE Buria] 24 FUNERA, DIRECTOR Scarpelli, Cumberland, Md. VR A15ME (5) 6M 1/67 1967



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11780 CERTIFICATE OF DEATH 11793 eral PLACE OF OEATH 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) MARYLAND o. COUNTY ALLEGANY b COUNTY OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after MARYLAND ALLEGANY c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 write RURAL and give nearest town) WESTERNPORT DAYS CUMBERLAND e IS RESIDENCE E 2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS within 72 ON A FARM? filled SACRED HEART HOSPITAL N MARYLAND AVENUE YES NO X NAME OF remove carbon Middle First 4 DATE Ooy Year completely DECEASED event, 19 67 (Type or print) MC KENZIE OFATH 20 GUY EDWARD IF UNDER 1 YEAR IF UNDER 24 HRS SEX 6. COLOR OR RACE AGE (In years 7. MARRIED TY **NEVER MARRIED** 8. OATE OF BIRTH 74 yrs. Months Doys Hours WIDOWED DIVORCED WHITE 09-23-92 ond in any MALE puo 10o JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? physician (nen pleose eose SCHONZEL KEYSER. WEST VIRGINIA CUSTODIAN 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal, MARGARET ANN FLEEK CHARLES MC KENZIE IS. WAS DECEASED EVER IN ILS ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service 215-10-8001 HOSPITAL RECORD - 200 SETON DR. . CUMB. . MD NO cremotion, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the buriol-tronsit p buriol, cremotic PART I. CEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital or attending physicion. **OUE TO** Cronio. Pullano Conditions, if ony, which gove HO RE TU nse to immediate couse (a), DUE TO stating the underlying couse os the lost. WAS AUTOPSY PERFORMED? has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) be detached for use State Dept. of Health YES 🗔 NO certificate 200 ACCIDENT WAS UNDERLYING [20b. OESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) 20x TIME OF INJURY Month, Ooy, Year ((County) (Stote) Æ Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work , 19 67, ta_ . 19 67, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. 9-17 9-20 9-20 19 67, and that death accurred at >36PM, from causes and on the date stated above. FUNERAL DIRECTOR: saw the deceased alive an_ 22o. SIGNATURE 22b. DATE SIGNED STAFF PHYS. ATTENDING director, poge 3 should be filed v M.D **OIRECTOR** PHYS 22d. AODRESS 126 N. 22r PHYSICIAN'S SMALLWOOD ST., C UMB., MD NAME (Type) SPIGGLE WAYNE 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL CREMATION. (County) (Stote) MEMOVAL (Specify) 9/23/67 Keyser Potomac Valley Gardens W. Va. 9 ADDRESS RECOURT REGISTRAR 24 FUNERAL DIRECTOR REGISTRAR'S SIGNATURE VR A15 (4) Westernport, 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11781 CERTIFICATE OF DEATH 11794 requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Allegany o. COUNTY Maryland Allegany MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing Lonaconing vrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS IS RESIDENCE ON A FARM? puper carbon oup Castle Street Castle Street NO X YES 🗍 3. NAME OF Middle 4. DATE Уеог Dov signed by the attending physician and completely, burial-transit permit. Then please remove carbon DECEASED TIFORD (Type or print) MARY DEATH 19 9. AGE (In years lost birthdoy) IF UNDER 24 HRS. 6 COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED **NEVER MARRIED** Months Doys Hours White WIDOWED T DIVORCED 3/16th Female 1Go USUAL OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY **COUNTRY?** Lonaconing, Md

14 MOTHER'S MAIDEN NAME None 13. FATHER'S NAME Elizabeth Lindsey John Seggie IS. WAS DECEASED EVER IN U.S. ARMED FORCES 16. SOCIAL SECURITY NO. 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) Henry Milford Lonaconing. Md. No None SUN INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c) PART I. DEATH WAS CAUSED BY-IMMEDIATE CAUSE (o) ONSET AND DEATH DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO stating the underlying couse as the priar to l has been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? Veloci/Um NO O FUNERAL DIRECTOR: After this certificate 205, DESCRIBE HOW INJURY OCCORROD, (Enter noture of Joury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING I Page 4 may be retained by the hospital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (City or town) (County) Hour o.m. foctory, street, office bldg., etc.) Not While of work ot work 0, 1967, that (I) (we) last 19.56 to 20 21. I certify that (1) (this haspital) attended the deceased from and that death accurred at 7 A. M. from tauses and on the date stated above. sow the deceased alive on sent. 1967 22b. DATE SIGNED 22o. SIGNATURE ATTENDING PHYS. PHYS directar, page 3 shavid be filed 22d. ADDRESS 22c. PHYSICIAN'S .R. MILESUR NAME (Type) LONACONING 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION. (County) (Stote) Burial (Specify) Oak Hill Cemeterv 9/12/1967 Lonaconing, Md. 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR VR A15 (4) George Eichhorn Lonaconing, 20 M 1/66 V

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 77795 11782 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) , 2, and 3 . o. COUNTY o. STATE b. COUNTY with the State Department of b CITY OR TOWN (if ourside corporate limits, write RURAL and give nearest town) MARYLAND Maryland Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) any delay c. LENGTH OF STAY IN 1b. Cumberland Cumberland d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress) d. STREET ADDRESS e IS RES DENCE ON A FARM? the certificate, writing the ward "pending" in penct in Item 18. Give Pages 1, " 4 should be farworded to the Chief Medical Examiner's Office along with farm YES Memorial Hospital 29_Ridgeway_ MEDICAL EXAMINER: This certificate should be executed within 24 haurs after death NAME OF Year DECEASED (Type or print) DEATH September 1967 Miller 8 DATE OF BIRTH IF UNDER 24 HR 6 COLOR OR RACE NEVER MARR ED 7 MARR ED lost birthdoy) Months Doys event within 72 haurs after death WIDOWED DIVORCED Oct. 12, 191/, 5 Male White 10o USUA, OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT 10b KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY COUNTRY? Pluming & Heating Engineer Cumberland

14. MOTHER'S MAIDEN NAME Maryland II.S.A 17. INFORMANT Louis Miller 16 SOCIAL SECURITY NO Address a burial-transit permit. (Yes, no, or unknown) (If yes give wor or doles of service) 212-18-1356 | Marie Miller 29 Ridgeway Terrace Yes INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I DEATH WAS CAUSED BY-Sudden DEATH Occlusion Coronary IMMED ATE CAUSE (o) **DUE TO** and in any Conditions, if any which gave 3 Coronary Sclerosis rise to immediate couse (o), DUE TO stoling the underlying couse be used 19 WAS AUTOPSY PERFORMED? PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) crematian, or removal, CERTIFICATION the certificate, NO X 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part i or Part 1 of item 18) 3 shauld b PRIMARY Fill or CONTRIBUTING [7] CAUSE OF DEATH MEDICAL 20e PLACE OF NJURY (Home, form 20d INJURY OCCURRED (City or Town) (County) 20c T ME OF INJURY Month, Day, Year Hour o.m. factory, street, office bldg . etc) may be retained for your FUNERAL DIRECTOR: Page ot work 2]. I certify that I taak charge of the remains described above, held an Autapsy ... Inspect on X. Inquiry 🛣 , and in my apinian Natural causes 🔽 , Accident Suicide . Undetermined manner funeral directar. death resulted fram: Hamicide [CHIEF MEDICAL EXAMINER Health prior ta ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER X September 6, 1967 EXAMINER'S BENEDICT SKITARELIC, M.D. Address (Street, city, town, or coftimberland. Maryland NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL, CREMATION, 50 REMOVAL (Specify) Sept. 9, 1967 Rose Hill Cometery Cumberland Allegany REGISTRAR 256 REGISTRAR S SIGNATURE MD. Buriel 250. REC'D BY REGISTRAR VR A15ME (\$) 6M 1/67 VCharles Judge



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11783 388 KK CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY Allegany b. COUNTY Maryland Allegany MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town)

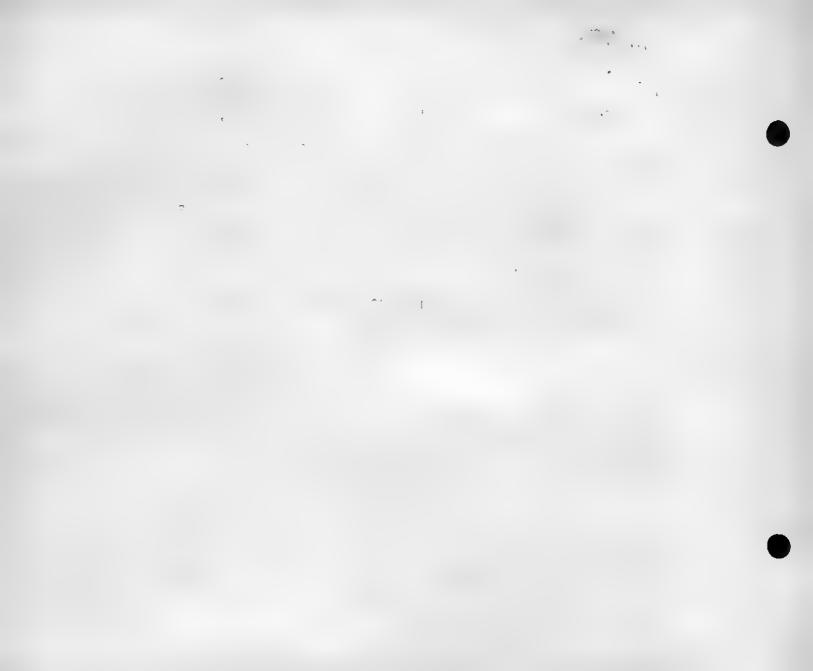
Cumberland CLENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) papers. Pag ′1 967 Cumberland d. NAME OF HOSPITA. OR INST TUTION (If not in haspital, give street address) d STREET ADDRESS 676 Greene Street IS RESIDENCE ON A FARM? Allegany County Infirmary NO IX NAME OF Middle Last 4. DATE Day Year completely DECEASED Be 110 Emma September 1967 Morris (Type or print) 9 AGE (In years 6 COLOR OR RACE DATE OF BIRTH 7. MARRIED IE LINDER I YEAR NEVER MARRIED White Manths Haurs Female 12/25/1880 WIDOWED X DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired)
Housewife INDUSTRY TICOUNTRY? Frosbburg, Maryland 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Smouse Daniel Mary Hitchins attending p 17. INFORMANT P.O. Box 599, Cumberland, Md. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war or dotes of service 20 Allegany County Infirmary records. 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c), INTERVAL BETWEEN PART 1. DEATH WAS CAUSED BY-IMMEDIATE CAUSE (a) ONSET AND DEATH TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires the Poge 4 may be retained by the hospital or ottending physicion. **DUE TO** signed Conditions, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? NO X 20a ACCIDENT WAS UNDER, YING □ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e. PLACE OF INJURY (Hame, form 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (C ty or flown) (County) (State) Hour a.m. factory, street, office bldg., etc.) Not While of work at work 21. I certify that (I) (this haspital) tended the deceased from , that (I) (we) last P • M, fram causes and an the date stated above FUNERAL DIRECTOR: sow the deceased alive an_ 67 and that death accurred at 22g SIGNATURE MED. DIRECTOR 22b DATE S GNED STAFF PHYS. 9/8/1967 M.D. director, poge 3 should be filed PHYSICIAN'S 22d. ADDRESS NAME (Type) Memorial Hospital. Cumberland. Md. 126C MONS 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23o BURIAL, CREMATION 23d LOCATION (City or Town) (County) (State) Alleg Md 9/11/67 Sunset Memorial Park Near Cumberland 9 ADDRESS 2Sq. REC'D BY REGISTRAR 256 REGISTRAR S SIGNATURE SEP 11 Balto Ave. CumberlandATE

MARYLAND STATE DEPARTMENT OF HEALTH

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+	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201								
FOR STATE	11784 M	EDICAL EXAMINER'S	CERTIFICATE OF DEATH	11797					
HEARTH SEAT.	PLACE OF DEATH O COUNTY ALLEGANY	MARY1AND	2 USUAL RESIDENCE (Where deceosed .ved, if nstitute o STATE MARYLAND	tion Residence before odmission) ALLEGANY					
fourty delay is 11, 2, and 3 to m. P.M3. Page Department of Lrs ofter death.	b. CITY OR TOWN (if outside torparate limits, write RURAL and give nearest town) FROSTBURG	D.O.A.	CLITY OR TOWN (If auts de carparate timits, write RU FROSTBURG	4					
Dep Dep	d NAME OF HOSPITAL OR INSTITUTION (If not in hospi	tal, give street oddress)	d STREET ADDRESS	e IS RESIDENCE ON A FARM?					
Poges 1, iith farm Stote De	MINERS HOSPITAL	No. II.		STREET YES NO X					
after death 1 8 Give Poges olong with far with the State	3 NAME OF First DECEASED (Type or pnnt) S SEX 6 COLOR OR RACE 7 MARR	Middle SILVER	Lost 4 DATE Mon OF DEATH SEPTEME PAGE (In years	BER 4 19 67					
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1 of haurs after death 1 in Item 18 Give Poge er's Office along with ges Land 2 with the Stol ony event minimized	100 LSLAL OCCUPATION (GIVE KIND OF OREMANIO during most of working his even I refred MINISTER-ROUNDHOUSE C	END OF BUSINESS OR CHURCH-RAILROA	BIRTHPLACE (State or foreign country) RIDGEWAY, WEST VA.	12 CITIZEN OF WHAT COUNTRY?					
within 24 pencil in xominer's ile pages nd in ony	13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
d with the Exon	HARRY MOULDEN 15. WAS DECEASED EVER IN ILS. ARMED FORCES?	14 COSTA, SECURITY AND A 1 17 1	DELLA MORGAN NFORMANI ETROMANI						
cuted ng" in dicol dicol ovol, i	(Yes no or unknown) (If yes give wor or dotes of service)	16 50514 SECURITY NO 11 8.	MATTER TO A	FBURG, MD. 57 WASHINGTON ST					
should be executed the ward "pending" in the Chief Medicol E burial-tronsit permit. F	IB CAUSE OF DEATH (Enter only one couse per line PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) THE TO	e for (a), (b), and (c).)	onary Occlusion	INTERVAL BETWEEN ON SET AND DEATH SUGGEN					
다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다	(b)	C	oronary Sclerosis						
is certifice, writing forworde s used os o buriol, o	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE	NG TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19 WAS ALTOPSY PERFORMED? YES NO **X					
AMINER: This of the certificate, et a should be for our files. age 3 should be u agent, priar to b	PRIMARY LL or CONTRIBUTING LL	DESCRIBE HOW INJURY OCCURRED	(Enter nature of injury in Part or Part II at item 18.)						
EXAMINER: ute the cert oge 4 shoul 'your files. 'Poge 3 shoul	Hour o m pm 19 of	Vhile Not While foch	CF OF NJURY (Home, form, 201 (City or town) cry, street, affice bldg , etc.)	(County) (State)					
NEXA xecute . Poge for you off: Pog or oted or oted or oten or	21 I certify that I taak charge of the			uiry (X), ond in my opn on					
se e sector med med resign	death resulted from. Natural causes X, Accident , Suicide , Homicide , Undetermined manner CHIEF MEDICAL EXAMINER								
pleose I direct retaine retaine to DIREC	SIGNATURE Denel dict Si	Estarelie	M.D. ASSISTANT MEDICAL EXAMINER .	. 4, 19672. DATE SIGNED					
TO DEPUTY MESCAL EXAM necessary, please execute the funeral director. Page 4 5 may be retained for your TO FUNERAL DIRECTOR: Page Health or its designated age	EXAMINED	SKITARELIC. M	DEPUTY MEDICAL EXAMINER A Address (Street, city, town, or count out to be	erland, Md.					
o DE the f the f Meart	230 BURIAL CREMATION 236 DATE THEREOF	23c NAME OF CEMETERY OR							
	BURTAL Specify) SEPT. 7, 19		PARK CUMBERIAN						
VR AISME	MANTEOUR SOWERS, HAF	'ER-SOWERS FUN W.MAIN, FROSTB	ERAL 250. RECD BY REGISTRAR 1967 She North BER AL DATE SEP 1 3 1967	Clianles Judge:					





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11786 11799 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DERT. I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. COUNTY o STATE b. COUNTY ALLEGANY MARYLAND MARYLAND ALLEGANY 3000 b CITY OR TOWN (If outside carparate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) 2, and PM3. E write RURAL and give necrest town) CUMBERLAND 40 YEARS CUMBERT, AND d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? This certificate should be executed within 24 hours after death. If a licate, writing the word "pending" in penal in Item 18. Give Pages 1, be forwarded to the Chief Medical Examiner's Office along with form DOA MEMORIAL HOSPITAL 913 FREDERICK STREET YES NO KO NAME OF First Middle Lost 4 DATE Day Month DECEASED **JESSIE** O'NEAL (Type or print) SEPT. DEATH SEX 6. COLOR OR RACE 7 MARRIED X NEVER MARR ED B DATE OF BRTH AGE (In years IF UNDER 1 YEAR F UNDER 24 HRS last birthdoy) Months Hours death WIDOWED D-YOR CED FEMALE AUG. 1.1902 WHITE 100. USUAL OCCUPATION (Give kind of work done TOB. KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY **COUNTRY?** HOUSEWIFE OWN HOME BOALSBURG, PA. USA 13. FATHER S NAME 14 MOTHER'S MAIDEN NAME CHARLES KLINGLER EMMA WOODS 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service event within NO NONE CLOYD O'NEAL CUMBERLAND. MD. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY CORONARY OCCLUSION STONSOT PHOTO DEATH IMMEDIATE CAUSE (a). DUE TO CORONARY Conditions, if any, which gave) SCLEROSIS rise to immediate couse (a). DUE TO stating the underlying couse PART I OTHER SIGN F (ANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) removal, 19 WAS AUTOPS PERFORMED? NO 9 20g EXTERNAL CAUSE WAS 20b DESCRIBE HOW NURY OCCURRED (Enter nature of injury in Part L or Part L of Item 18) 5 PRIMARY G or CONTRIBUTING G 4 should CAUSE OF DEATH cremotion, 20¢ TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or town) (County) foctory, street, office bldg., etc.) Nat While DIRECTOR: Page at work at work 21. I certify that I taak charge of the remains described above, held an Autopsy ... Inspection [X], Inquiry X. and in my apmian director. Natural squises XX. Accident ... death resulted fram: Suicide Hamic de Undetermined manner CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER moy be re SIGNATURE the funerol DEPUTY MEDICAL EXAMINER X **EXAMINER'S** CUMBERIES (Siget, city town, or county) NAME (Type) BENEDICT SKITARELIC, M.D. 23d LOCATION (City or Town) 230 BURIAL, CREMATION. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 400 REMOVAL (Spec fy) SEPT. 14,1967 SUNSET MEMORIAL PARK CUMBERLAND. MD. BURIAL 24 FUNERAL DIRECTOR 250 RECD BY REG STRAR VR A15ME (5) CUMBERLAND, MD. 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11400 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY O. STATE WEST VA. b. COUNTY **ALLEGANY** MINERAL MARYLAND b CITY OR TOWN (If autside carparate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) Write PURAL BYE RYE ARRIST TOWN) DAYS RIDGELEY 26753 d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENC ON A FARMS SACRED HEART HOSPITAL-900 SETON DRIVE 60 KNOBLEY ST. YES 40 3. NAME OF 4. DATE last Month Day Year DECEASED COLUMBUS JACKSON PHILLIPS SEPTEMBER 19 67 (Type or pnnt) DEATH S SEX 6 COLOR OR RACE 8 DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED 9. AG [In years NEVER MARRIED 85birthday) Months 1-29-82 MALE WHITE WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (C nty & State, or fareign country) 12. CITIZEN OF WHAT Enforcement querind 1/02 of AloC fed In the Leaving Estated) E Agenci COUNTRY? COUNTY, WEST VA. USA 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME or remayal, ABRAHAM PHILLIPS MARGARET RAMSEY 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, popr unknown) (If yes give war or dates of service 234-12-4074 PTS.HOSPITAL CHART SACRED HEART HOSP burial, cremation, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by **DUE TO** Conditions, if any, which gove rise to immediate cause (a). **DUE TO** stating the underlying cause as the last. PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO 200 ACC DENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Page of Part II of item 18. OR CONTRIBUTING CLAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20e PLACE OF INJURY (Hame, form, 20d INJURY OCCURRED 20f (City or fawri) ((county) (State) factory, street, office bldg., etc.) at work at work 21. I certify that (1) (this haspital) attended the deceased fram 9-25-67 . 19 9-29-67, 19___, that (I) (we) last , ta____ saw the deceased alive an 9-29-67 19 and that death accurred at 10:55M,AMm causes and on the date stated above 220 SIGNATURE 22b DATE SIGNED ATTENDING DIRECTOR PHYS 10-2-67 PHYS 122 SOUTH CENTRE ST. CUMB., MD. 276 PHYSICIAN'S MILTENBERGER, M.D. NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION, 23d LOCAT ON (City or Town) (County) BULLAL (Specify) Elkins, Randolph. W. Maplewood Cometery 10/2/67 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 25b. REGISTRAR 5 SIGNATURE VR A15 (4) 25M 1/67 H. Wayne George Cumberland, Md. Minela Judas

¥ _____ 1 4 1 15 -7 1, 5, 2, 5 6 1, 5 5 77, 4 5 T; 4 (1.5) · To · · 25.-12-, 7 TS. 5" T L . . T S T . . . T

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11788 CERTIFICATE OF DEATH 11801 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) o. COUNTY b. COUNTY ALLEGANY MARYLAND b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) write RURAL and give georest town KEYSER WEEKS d. NAME DF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENC ON A FARM? MEMORIAL HOSPITAL MAIN STREET NO X carbon NAME OF Middle First Year DECEASED ROBERT REID SEPTEMBER 19 67 PAUL (Type or pant) IF UNDER 1 YEAR IF UNDER 24 HRS 8 DATE OF BIRTH AGE (In years 6. CDLOR OR RACE 7. MARRIED X NEVER MARRIED lost birthday) Months Dovs Hours 5-30-1899 WHITE and in any MALE WIDOWED DIVORCED and 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS DR 11. BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT ite, even firetired) Chief Fire Dept COUNTRY? CUMBERLAND. MARYLAND USA 13. FATHER S NAME 14 MOTHER'S MAIDEN NAME or remayal, ROBERT REID MARY BAKER 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war or dates of service) 217-30-1269 MEMORIAL HOSPITAL, CUMBERLAND. NO cremation, NTERVAL BETWEEN 18. CAUSE OF DEATH (Enter on y one couse per line for (a), (b) and (c).) ONSET AND DEATH -transit PART I. DEATH WAS CAUSED BY \$ 15 moid arcino Mer IMMEDIATE CAUSE (o) DUE TO buria Conditions, if ony, which gove rise to Immediate couse (a). DUE TO stating the underlying couse as the priartal has PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 160 WAS AUTOPS PERFORMED? Health NO 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (Stote) 20c. TIME OF JUJRY Month, Doy, Year (City or fown) (County) foctory, street, office bldg., etc.) 21. I certify that (1) (this hospital) attended the deceased from ang 24 19 67, to Sela 3 _____, 19<u>67</u>, that (1) (we) las be retained 19 67, and that death occurred of 2:00A, 1Mm causes and on the date stoted above sow the deceosed olive on Safe Z TO FUNERAL DIRECTOR: 22o SIGNATURE 22b. DATE SIGNED STAFF MD 22c. PHYSICIAN'S NAME (Type) DR. FAW CUMBERLAND. MARYLAND 23d LOCATION (City or Town) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION. (County) REMOVAL (Specify)
Burial 9/6/67 Rosehill Cemeterv Cumberland Allegany Maryland 24. FUNERAL DIRECTOR 250 REC D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE DATE SEP H.Lee Silcox Cumberland, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11802 FOR STATE HEALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE Maryland o COUNTY b COUNTY Allegany Allegany c CITY OR TOWN (f outside corporate i mits, write RURAL and give nearest town) b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) r LENGTH OF STAY IN 16 Cumberland 5 days
d NAME OF HOSPITAL OR INSTITUTION (Finct in hosp to give street address) Mt. Savage
d. STREET ADDRESS » IS RESIDENC ON A FARM? Memorial Hospital Route#1 Mt. Savage NO TX in Item 18. Give Pages 3 NAME OF 4 DATE DECEASED DEATH Retzer Sept. 8 DATE OF BRIH 1886 9 AGE (In Years ost birthdoy) 6 COLOR OR RACE 7 MARRIED X NEVER MARRIED Months Nov.15, WIDOWED White Male 11 BIRTHPLACE (State or foreign country) 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUS NESS OR 12 CITIZEN OF WHAT during most of working life, eyen if retired) INDUSTRY COUNTRY? Clearfield, Pa.
14 MOTHER'S MAJDEN NAME B&O Railroad laborer (Retired) 13 FATHER'S NAME Barbara Ellen Hawk Joseph Retzer 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dates of service Mrs. Ella Retzer Rt.#1 Mt. Savage, Md. 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY Acute Cardiac Failure IMMEDIATE CAUSE (o) _ 4. 2011 DUE TO Conditions, if ony, which gove Arteriosclerotic cardiovascular disease. rise to immediate couse (a). Cor Pulmonale; Silicosis; Emphysema DUE TO stoting the underlying couse 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) YES X NO Fracture of left Hip. 20b DESCR.BE HOW NULRY OCCURRED (Enter nature of injury in Port Lor Port Lof item 18.) 200 EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH Fell at home 20c TIME OF INJURY Month Doy, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home, form, 20f (City or fown) (County) While of work IX Home foctory street, office bidg , etc.) Mt.Savage, Alleg. Maryland -Sept. 26 1967 21 I certify that I took charge of the remains described above, held an Autapsy X, Inspection X, inquiry XX and in my apin an death resulted fram Natural causes , Accident Suicide , Homicide Undetermined manner CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER IX September 30, 1967 **EXAMINER'S** BENEDICT SKITARELIC, M.D. Address (Street, cly, lown or Orthberland, Maryland

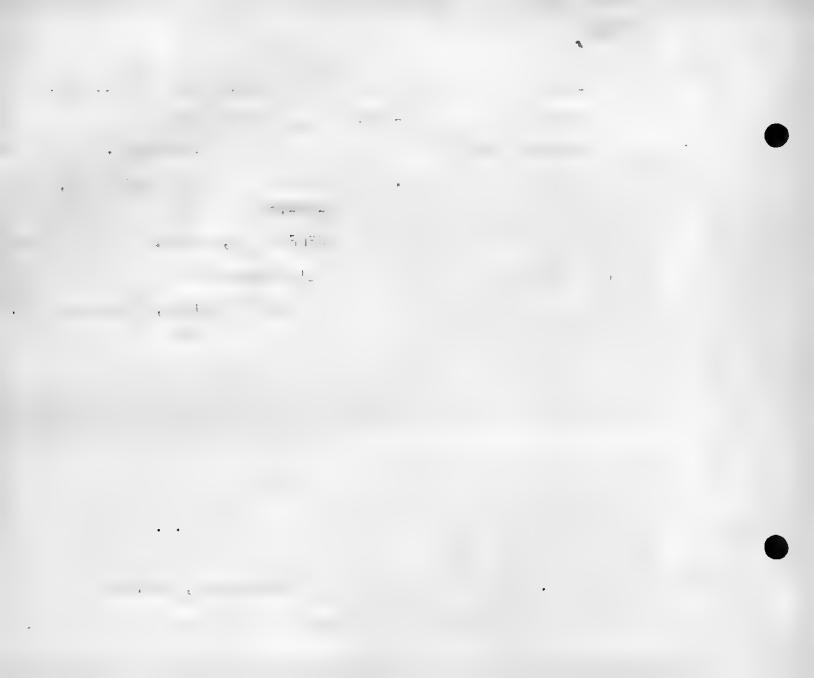
Y 23d LOCATION (City or Town) (County) (Stot NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 230 BURIAL, CREMATION REMOVAL (Specify) Oct. 3. 1967 St. Patricks Cemetery Mt. Savage Allegary
ADDRESS 250 RECD BY REGISTRAR 256 REGISTRAR'S STONAL RE burial 24 FUNERAL D RECTOR Mcharles Judge VR A15ME (5) H. Lee Silcox 404 Decatur St. Cumb. Md. ___ DADGT



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11803 requires that the death certificate be executed within 24 haurs after death. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH attending physicion and campletely filled in by the funeral sernit. Then please remove carban papers. Pages I and Allegany o. STATE b. COUNTY Maryland Allegany o. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate imits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 3 vears Cumberland d STREET ADDRESS IS RESIDENC d. NAME OF HOSPITA. OR INSTITUTION (If not in hospital, give street address) ON A FARM 300 Bedford Street Sylvan Retreat NO X 4 DATE First Middle Lost Month Doy Year NAME OF 19 67 DECEASED Robertson Sept. Estella Hester 12 DEATH (Type or print) IF UNDER 24 HRS IF UNDER SEX 6 COLOR OR RACE NEVER MARRIED 8. DATE OF BIRTH AGE (In years 7. MARRIED fost birthday) Months Doys Hours Female White 2/11/77 WIDOWED DIVORCED 90 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT 10b K+ND OF BUSINESS OR 10o USUAL OCCUPATION (Give kind of work done ar remayal, and in COUNTRY? U.S.A during most of working life, even if retired) INDUSTRY Midland, Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Martz Mary Isaac Stevenson Address 16. SOCIAL SECURITY NO 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) Howard E.Robertson Cumberland Md INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).) signed by the bursal-transit p DASET AND DEATH PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate cause (o), DUE TO stoting the underlying couse te O FUNERAL DIRECTOR: After this certificate has been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL PISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPS)
PERFORMED? CERTIFICATION 205, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (County) 20e PLACE OF INJURY (Home, form, (City or town) (State) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Hour o.m. Not While ot work at work Sept.12 6/ 19 0 / . to 12 .. that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram_ April be retained director, page 3 shauld shauld be filed with the Sept. 11 1967 and that death accurred at 4 AM, from causes and an the date stated above saw the deceased alive on. 22b. DATE SIGNED 220 SIGNATURE MED. DIRECTOR STAFF PHYS. ATTENDING M.D. PHYS 22d ADDRESS 22c PHYSICIAN'S NAME (Xype Memorial Hospital, Cumberland, Md. Mopper. M.D. John 23d LOCATION (City or Town) (Stote) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION REMOVAL (Specify) Burial Md Frostburg Memorial Park. Frostburg 25b. REGISTRAR'S SIGNATURE 250, RECD BY REGISTRAR 24. FUNERAL DIRECTOR 1967 Eichhorn Lonaconing, Md. George 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11791 11804 CERTIFICATE OF DEATH O HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY ALLEGANY MARYLAND **ALLEGANY** filled in by the for papers. Pages than 72 hours afte b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 1h c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) write RURAL and give nearest town) 1WK-1DAY CUMBERLAND CUMBARLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in haspital, give street address) d STREET ADDRESS e IS RESIDENC ON A FARM? filled BALTIMORE MEMORIAL HOSPITAL YES №0 NAME OF Middle Lost remove corbon physicion ond completely DEATH SEPTEMB DECEASED (Type or print) MINTA ROBERTSON 6. COLOR OR RACE 7 MARRIED NEVER MARRIED lost hirthday) Months WHITE WIDOWED DIVORCED !Do. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 12. CIT ZEN OF WHAT 11 BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if refired)
PRACTICAL NURSE
13 FATHER'S NAME INDUSTRY **COUNTRY?** BEDFORD CO. PENNA. USA 14. MOTHER'S MAIDEN NAME ar removol. WILLIAM ROBERTS ELIZA XBROWN Bowman IS. WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) MEMORIAL HOSPITAL CUMBERLAND. 18. CAUSE OF DEATH (Enter only one couse per line for (e), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) NTERVAL BETWEEN buriol-tronsit DUE TO Conditions, if ony, which gove rise to immediate cause (a), DUE TO stating the underlying couse this certificate has been 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) No 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 20o. ACC DENT WAS UNDERLYING [7] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 2Dc. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) Hour 'o.m. foctory, street, office bldg., etc.) 1965 to 201-714, 190/, that (1) (we) las 21. I certify that (I) (this hospital) attended the deceased from forne 1967 and that death accurred at 11:20 Pom Mauses and an the date stated above saw the deceased alive an TO FUNERAL DIRECTOR: 220 SIGNATURE 22b DATE SIGNED 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) DR. DURRETT CUMBERLAND. MARYL AND 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIA., CREMATION. 23b DATE THEREOF (County) (Stote) REMOVAL (Specify) Zion Cemetery Burial 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 H.Lee Silcox 404 Decatur St, Cumb. Md



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11805

11792

FOR

P.M.3 Page

with the state Department of

'pending" in pencil in Item 18. Give Pages 1, 2, and 3 ta

Page 4 shauld be farwarded to the Chief Medical Examiner's Office along with farm

necessary, please execute the certificate, writing the ward

the funeral directar.

VR A 15ME (5)

TO DEPUTY MEDICAL EXAMINER:

5 may be retained far yaur files. TO FUNERAL DIRECTOR: Page 3 shauld be used as a burial transit permit. File pages Tand 2, Health prior to burial, crematran, or remayal, and in any event within 72 haurs after dear

This certificate shauld be executed within 24 haurs after death

delay is

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH	2 USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission)			
o. COUNTY Allegany MARYLA	o STATE Maryland b. COUNTY Allegany			
b CITY OR TOWN (if outside corporate himits, C LENGTH OF STAY IN)				
write RURAL and give nearest town) Cumbercana	Cumberland.			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS e 5 RESIDENCE			
D. O. A. Memorial Hosp.	121 N. Allegany St. YES NO X			
3 NAME OF First Middle	Lost 4 DATE Month Day Year			
(Type or print) Herman Jule	Rolley DEATH September 7, 1967			
5 SEX 6 COLOR OR RACE 7 MARRIED WEVER MARRIED	8 DATE OF BIRTH 9 AGE (IN years IF UNDER 1 YEAR IF UNDER 24 HRS			
Male White WIDOWED DIVORCED	Nov. 29, 1886 lost birthday) Months Doys Hours Min.			
100 USUAL OCCUPATION (Give kind of work done 10b KIND OF 8USINESS OR	11 8IRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT			
during most of working life, even if retired) Ket. Machinist Kelly Tire Co.	Frenchville, Penna. (Buntey? A.			
13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME			
Francis Rolley	Mary Ann Berthot			
15 WAS DECEASED EVER IN US ARMED FORCES? 16 SOCIAL SECURITY NO	17 SMEODAGAMT			
(Yes, ng. or unknown) (If yes give war or dotes of service) 214-07-0393	Mrs. Goldie L. Rolley 121 N. Allegany St.			
18 CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c))	NTERVA, BETWEEN			
PART I. DEATH WAS CAUSED 8Y	CORONARY OCCLUSION SUDDEN			
420/ IMMEDIATE CAUSE (o)	DRUMARY VECTUSTUM SUPPEM			
Conditions of any, which gave 3 (6)	CORONARY SCLEROSIS			
rise to immediate couse (a), (a) to the course (b), (
stating the underlying couse lost. (c)				
PART IL OTHER SIGNIFICANT CONDITIONS CONTR & TING TO DEATH RUT NOT RELATE	D TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY			
200 EXTERNAL CAUSE WAS 200 DESCRIBE HOW INITIALLY OCCU	PERFORMED?			
20a EXTERNAL CAUSE WAS 20b DESCR 8F HOW INJURY OCCU	RRED (Enter nature of injury in Port I or Port II of Item 18)			
FRIMARY OF CONTRIBUTING CAUSE OF DEATH				
20c T.ME OF INJURY Month, Doy, Year 20d N.JRY OCCURRED 20	De PLACE OF INJURY (Home, form, 20f (City or town) [County] (State)			
Hour om. While Not While	foctory, street, office bldg , etc.)			
21. I certify that I taak charge of the remains described above	/e, held an Autapsy , Inspection X, Inquiry X, and in my opinia			
death resulted fram. Natural causes X. Accident				
dedili resolled Italit. National causes [3], Accident [],	Suicide [], Hamicide [] Undetermined manner [] 9/8/67			
ACTUAL SOLVET TO THE	OO DAYE CHOUSE			
SIGNATURE X Level dest X Tolars	DEDUTY MED CALEVANA ED 181 K.C. # 9			
EXAMINER'S Benedict Skitarelic, M.D.	Address (Street, city, town, or county) Cumberland, Md.			
230 BUR AL CREMATION 23b DATE THEREOF 23c NAME OF CEMETER				
REMOVAL (Spepty)				
Switch 9/11/67 SS. Poton	& Paul Com. Cumberland, Allegany Md.			
BWYCHELY 9/11/67 SS. Peter 24. FUNERAL DIRECTOR H. Wayne George Cumberland. Marylan	250. REC'D BY REGISTRAR 256 REGISTRAR'S S GNATURE			

11793tem #2d Film #332 9/19/5/ ph 11806 MÉDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DERT I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, functitution Residence before admission) o. COUNTY o. STATE b. COUNTY deray is and 3 to M3. Page Allegany MARYLAND Maryland Allegany b CITY OR TOWN (if outside corporate imits, write RURAL and give nearest tawn) c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) pup 2, and PM3. State Departme 65 years Cumberland Cumberland d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS Elycold de/ Office arang with farm d "pending" in pencil in Item 18. Give Pages 1, Chief Medical Examiner's Office arang with farm County / Home Memorial Hospital NO bo This cert ficate shauld be executed within 24 hours after death NAME OF Middle DATE Manth Lost Year DECEASED OF 19 67 Thomas Patrick Rooney Sept. 13 (Type or print) DEATH IF UNDER 24 HR 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED 88 birthdoy) Months Dec. 18. 1878 Male event within 72 haurs after death White WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? West Moreland, Pa. USA none none 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME File Patrick Rooney Anna King 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO Address Niece (Yes, no, or unknown) (If yes give wor or dotes of service) Mrs. Robert Blanchard, Cumberland, Md. IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-trans# PART I. DEATH WAS CAUSED BY Chronic Myocarditis IMMEDIATE CAUSE (o) please execute the certificate, writing the ward DUE TO the any Arteriosclerotic Cardiovascular Conditions, flony which gove rise to immediate couse (o), Disease DUE TO stating the underlying couse 19 WAS AUTOPSY PERFORMED? ar removal, PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(G) Fracture left femur and humerus NO X Page 4 shauld be 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port | or Port | of Item B) 3 shauld PRIMARY Or CONTRIBUTING EDITAL EXAMINER: Fell at county home CAUSE OF DEATH crematian, 20e PLACE OF NJURY (Home, form, 20c TME OF NJURY Month, Doy, Year 20d NJURY OCCURRED (City or town) (County) While at work of work County Home FUNERAL DIRECTOR: Page sept. 9 19 67 Cumberland, Alleg., Md. 21 I certify that I took charge of the remains described above, held on Autopsy , Inspection XX angu ry XX and in my apinion Accident X Undetermined monner death resulted from. Suicide Homic de be retained CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER 7 9-13-1967 22 DATE SIGNED necessary, DEPUTY MED CAL EXAMINER Rt.9 Cumberland Benedict Skitarelic, M.D. 5 may TO FUNE Hea th NAME (Type) Address (Street, city, town, or county) 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL CREMATION. 23b DATE THEREOF 23d. (OCATION (City or Town) Sept.14.1967 St. Mary's Cemetery Cumberland Md.Allegany 250 RECD BY REGISTRAR
SFP 15 24 FUNERAL DIRECTOR VR A15ME (5) Scarpelli, Cumberland, Md. 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH 11794 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11807 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAM: The law requires that the death certificate be executed within 24 hours after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY ALLEGANY b. COUNTY ALLEGANY o STATE MARYLAND MARYLAND b. CITY OR TOWN (If outside corporate limits. C. LENGTH OF STAY IN 16 c CITY OR TOWN (If purside concernte limits, write RURAL and give nearest town) uve edrban gapers. Page write RURAL and give negrest fawn)
CUMBERLAND DAYS in by d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESOSS ST. e IS RESIDENCE ON A FARM? MEMORIAL HOSPITAL YES NO [3. NAME OF Middle First ROSS 4. DATE Day Year completely DECEASED JOHN 67 SEPTEMBER (Type or print) DEATH 19 B. DATE OF BIRTH 3-20-07 S. SEX 6 COLOR OR RACE 7. MARRIED AGE (n years IF JNDER 24 HRS **NEVER MARRIED** Manths Hours WHITE MALE WIDOWED DIVORCED 1Do. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT WESTERNPORT, MD. during most of working life, even if retired) **INDUSTRY** 13. FATHER S NAME 14 MOTHER'S MAIDEN NAME ROSSELLEN or removo DUNK WILLIAM M. ROSS attending p IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. permit (Yes, no prunknown) [(If yes give war ar dates of service) 217-09-2416 THE CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (s), PART I. DEATH WAS CAUSED BY: by the INTERVAL BETWEEN burial-transit **ONSET AND DEATH** nesothelume -1MMEDIATE CAUSE (a) DUE TO buriol, Conditions, if any, which gove (b) rise to immediate cause (a), **DUE TO** stating the underlying cause **TO HOSPITAL OR ATTENDING PHYSICIAN:** The taw re Poge 4 may be refoined by the hospital or ottending this certificate has been PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? Health ! NO 20g ACCIDENT WAS JNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item IB) OR CONTRIBUTING CAUSE OF DEATH etoched (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Day, Year 2Dd INJURY OCCURRED 2De, PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour a.m. While Not While factory, street, affice blda, etc.) 21. I certify that (I) (this haspital) attended the deceased fram director, page 3 should should be filed with the M. Fram Couses and and that death accurred at TO FUNERAL DIRECTOR: saw the deceased alive an Lant 19 67 an the date stated above 22g SIGNATUR 22b DATE SIGNED STAFF M.D. DIRECTOR PHYS PHYS 22c. PHYSICIAN'S 22d ADDRESS CUMBERLAND, MD. NAME (Type) HIMMELWRIGHT BURIAL, CREMATION NAME OF CEMETERY OR CREMATORY (County) PEMOENT (Specify) ilos 24. FUNERAL DIRECTOR **ADDRESS** 2Sq. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Westernport, Md. 196 DATISEP



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11808 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death by the funeral Pages 1 and 2 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) n COUNTY o STATE b. COUNTY ALLEGANY MARYLAND ALLEGANY b CITY OR TOWN (If outside carparate iimits, r LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 8 DAYS FROSTBURG d. STREET ADDRESS B IS RES DENCI d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL 206 E. MAIN STREET YES 🔲 NO X NAME OF First DATE Day Year DECEASED OF DEATH physician ond completed en please remove carbo RUGE ROBERT G. SEPTEMBER Type or print) 16. 19 8. DATE OF BIRTH AGE (In years F UNDER 1 YEAR IF UNDER 24 HRS S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Months Davs Hours MALE WHITE WIDOWED DIVORCED DECEMBER 14. 1901 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11, BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? POWDER MARYLAND II.S.A 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removol, ROBERT J. RUCE FRANCES SCHREIBER signed by the ottending burial-transit permit. The 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war or dates of service) 214-05-9642A MISS ELIZABETH RUGE. FROSTBURG. MD. INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise ta immediate cause (a), DUF TO stoting the underlying cause hos been be detached for use os the Stote Dept. of Health prior to last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? CERTIFICATION NO K O FUNERAL DIRECTOR: After this certificate PHYSICIAN: 20o ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING FT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year Hour o.m. factory, street, office bldg., etc.) Not While at work at work 1962, to Lest 16, 1962, that (1) (we) last 21. I certify that (I) (this hospital) attended the deceased fram 1947, and that death occurred at 3 2 A.M., from causes and an the date stated above. sow the deceased alive on \$/15 22o. SIGNATURE DATE SIGNED STAFF PHYS. director, page 3 should be filed v M.D. DIRECTOR PHYS 22d ADDRESS 167 E 22c PHYSICIAN'S E. MAIN ST., FROSTBURG, MD. RONG NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF 23o. BURIAL, CREMATION, (County) (State) REMOVA (Specify) ST. MICHAELS CEMETERY FROSTBURG, MD. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR JOSEPH R. DURST, SR., FROSTBURG, MD.



Stat

18. Give Pages 1, 2, form PM3. Page in File pages 1 and

puo

Office

Plnods

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should be FUNERAL

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VR A15ME 5M 1/62

certif

EXAMINER: This certificate should be

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11797 CERTIFICATE OF DEATH MIRIN law requires that the death certificate be executed within 24 hours after death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. STATE Maryland D. COUNTY b. COUNTY filled in by the fund Allegany MARYLAND c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) Midland d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Miners Hospital YES NO X e cgrbon NAME OF First Middle Lost 4 DATE Day Year DECEASED B. SMITH 9/6/1967 GERTRUDE 19 DEATH (Type or print) 9. AGE (In years IF UNDER 24 HRS. S SEX 8 DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED eve birthday) Months Dovs Hours Female White WIDOWED /16/1895 DIVORCED signed by the attending physician and burial-transit permit. Then please rem ID GI 100 JSUAL OCCUPATION (Give kind of work done during most of working live even if retired)

TOUSE WILE TOB. KIND OF BUSINESS OR 1) BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT INDUSTRY West Virginia 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or remayal, Thomas Bradev Anna Moran WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, prunknown) (If yes give war or dates of service) Smith Edward Midland, Md. INTERVAL BETWEEN ONSET AND DEATH Husband CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove rise to immediate cause (o), DUE TO ed far use as the b caf Health prior tab stoting the underlying couse this certificate has been last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPS) PERFORMED? TO HOSPITAL OR ATTENDING PHYSICIAN: The CERTIFICATION NO 20o ACCIDENT WAS UNDERLYING 205, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 18.) OR CONTRIBUTING

CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (Steta) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) Hour o.m. Not While factory, street, office bldg , etc.) of work TO FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased fram. Page 4 may be retained director, page 3 shauld should be filed with the 1967, and that death occurred at 2 C.M. from causes and an the date stated above. saw the deceased alive an Se 220. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S LONACONIN NAME (Type) NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23b, DATE THEREO! (County) 23o BURIAL CREMATION. Burial (Specify) 9/9/1967 Michaels Cemetery Frostburg 25b REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/60 1967 George Eichhorn Lonaconing, Md.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11798 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY **ALLEGANY** MARYLAND MARYLAND ALLEGANY b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) CUMBERLAND 11 DAYS CUMBERLAND papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? campletely-fulled in SACRED HEART HOSPITAL 703 FREDERICK ST. YES □ NO K NAME OF First Middle 4 DATE Month Doy DECEASED SEPTEMBER NELL DREYER BMITH 19 67 (Type or print) DEATH S SEX 6. COLOR OR RACE 8 DATE OF BIRTH IF UNDER 1 YEAR IF JNDER 24 HRS 7 MARRIED **NEVER MARRIED** AGE (In years lost burthday) 4-22-1891 FEMALE WHITE WIDOWED and in any DIVORCED The USUAL OCCUPATION (Give kind of work done 1Db KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if gettred) INDUSTRY COUNTRY? TEACHER CUMBERLAND. MD. (ALLEGAN U.S.A 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME ar remayal, **ELIZABETH** GEORGE DREYER (KAISER) IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) {(If yes give wor or dates of service) 220-10-8913 HOSPITAL RECORDS burial, cremation, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) Ono 21 01) TO HOSPITAL OR ATTENDING PHYSICIAN: Th≡ law requires the Page 4 may be retained by the hospital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse be detached far use as the State Dept. of Health priar to 19. WAS AUTOPSY PERFORMED? has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CAT ON NO F 20o ACCIDENT WAS JNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 1 of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOT FY MEDICA, EXAMINER 20e. PLACE OF INIURY (Home, form, 2Dd INJURY OCCURRED (Stote) 20c TIME OF INJURY Month, Dov. Year (City or fown) (County) Hour 'o.m. foctory, street, office bldg., etc.) Not While ot work of work 19 66, ta_ Plue 6 . 19.62, that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from ________ director, page 3 should shauld be filed with the 10.8.6 19.67, and that death accurred at 8 AM, fram causes and an the date stated above. O FUNERAL DIRECTOR: saw the deceased alive an 22b. DATE SIGNED 220. SIGNATURE STAFF PHYS DIRECTOR 22d ADDRESS 22c PHYSICIAN S NAME (Type) 126 N CUMBERLAND MD SPIGGLE SMALL WOOD ST 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY BUR AL, CREMATION, 23d LOCATION (City or Town) (County) Burial Burial Hillcrest Burial Park Cumberland Allegany Maryland 24. FUNERAL DIRECTOR H. Lee Silcox ADDRESS 250 REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE 196 404 DECATUR ST. Cumb, Mobale SEP SILCOX FUNERAL HOME

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11812 CERTIFICATE OF DEATH deoth, requires that the deoth certificate be executed within 24 hours after death. physician and completely filled in by the funeral PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE b. COUNTY ALLEGANY MARYLAND ALLEGANY b, CITY OR TOWN (If outside carparate limits, c LENGTH OF STAY IN Th CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) write RURAL and give nearest tawn)
FROSTBURG ECKHART d NAME OF HOSP TAL OR INSTITUT ON (If not in hospital, give street address) d. STREET ADDRESS IS RES DENG ON A FARM? NO X YES NAME OF Middle First Last 4. DATE Manth Day Year DECEASED SNYDER CHARLES ERVIN DEATH SEPTEMBER 19 67 (Type ar print) SEX 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED X **NEVER MARRIED** last birthday) Months Davs Haurs WIDOWED DIVORCED 27.7894 WHITTE MATE 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
CUS COCIAN COUNTRY? SCHOOL ECKHART, MARYLAND 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME PETER ROSA MAY LANCASTER SNYDER IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Addres ROSTBURG, MD. (Yes, no, or unknown) [(If yes give war or dates of service) C. SNYDER .R.F.D CAUSE OF DEATH (Enter only one couse per line, for) (a), (b) and (c).) INTERVAL BETWEEN signed by the buriof-tronsit p PART I. DEATH WAS CAUSED BY ONSEL AND DEATH IMMEDIATE CAUSE (a) DUE TO Conditions, if only, which gove rise to immediate cause (a), DUF TO stating the underlying couse os the O FUNERAL DIRECTOR: After this certificate has been last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AJTOPSY PERFORMED? CERTIFICATION NONO NO X for 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or fowrl) (State) TIME OF INJURY Month, Day, Year factory, street, office bldg. etc.) 1966, to 9_, 1967, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased from and that death accurred at 3:50 AM, fram causes and an the date stated above. saw the deceased alive an_ 22a SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS M DIRECTOR M.D. PHYS director, poge should be filed 22d. ADDRESS 22c. PHYSICIAN'S TO HOSPITAL NAME (Type) BROADWAY 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23a BURIAL CREMATION 23b. DATE THEREOI (County) (State) ECKHART ALLEGANY SOWERS . HAFER - SOWERS 2So REC'D BY REGISTRAR 256. REGISTRAR S SIGNATURE SOWERS, HAFER-SOWERS FUNERAL NUMBER OF W. NAIN, FROSTBUR SEP 5 196



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 24 hours after death, and PLACE OF DEATH USUAL RESIDENCE (Where deceased fixed, if institution: Residence before admission) a. COUNTY b. COUNTY e. STATE Pages 1 irs after Allegany

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MARYLAND Maryland Allegany
c, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b physician and completely filled in by a please remove partner, papers, Pagral, and in any event, within 72 hours Cumberland Cumberland Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) o. IS RESIDENCE ON A FARM? d. STREET ADDRESS 10 Decatur Street NO E 10 Decatur Street YES executed within NAME DE Middle DATE Last Month Year DECEASED (Type or print) DEATH 19 Wagoner Chomas September AGE (in years | IF UNDER 1 YEAR | IF UNDER 24 HRS 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months | Days Hours WIDOWED Y Female | White | WIDOWED | DIVORCET DIVORCED July 24 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT death certificate be during most of working life, even if retired) INDUSTRY COUNTRY? U S Housewife W. Va Hampshire Co. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME геточа John Wagoner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Sarah Milslagle 16. SOCIAL SECURITY NO. 17. INFORMANT Address Cumberland, Md 5 (Yes, no, or unknown) | (If yes give war or dates of service) signed by the attronuist-transit permi Magnolia Court None Irs. Howard Goover No 18. CAUSE OF DEATH [Enter only one cause per line jen (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: or attending physician. IMMEDIATE CAUSE (a) been signed the burial-tring for to burial, c **DUE TO** Conditions, if any, which (b) gave rise to immediate **DUE TO** cause (a), stating the underlying cause last. 38 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health PERFORMED? CATI certificate YES -ND T CERTIFI PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part 11 of Item 18.) Ö, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While retained by p.m. at work at work OIRECTOR: A age 3 should led with the S 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at _M. from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE 22b. Page 4 may be page MED. DIRECTOR STAFF FUNERAL PHYSICIAN'S director, p NAME (Type) Virginia Ave.. Cumberland. Md. Clay E. Durrett BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 9/6/67 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY (State) 2 Near Cumberland, Maryland Mary's Cemetery 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 196 Cumberland DATESEP VR AL5 (4) Jr to Ave 20M



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11801 CERTIFICATE OF DEATH 11814 requires that the death certificate be executed within 24 hours after death death puo the ottending physicion and completely filled in by the funeral isst permit. Then please remove carbon papers. Pages I and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) p. COUNTY o STATE Mary land **b.** COUNTY Allegany Allegany MARYLAND b CITY DR TDWN (if outside corporate limits, write RURAL and give necrest town)

Cumberland E LENGTH DE STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d. STREET ADDRESS B IS RES DENCE ON A FARM? Allegany County Infirmary 134 Elder Street YES THE NO DE NAME OF DECEASED First Middle 4 DATE Month Year Tingler Blanche E. September 67 DEATH (Type or print) 19 6 COLDR OR RACE SFX AGE (In years F LINDER 1 YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED Rest birthdoy) 1/15/1878 Doys Hours Female White WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT INDUSTRY U COUNTRY? West Virginia Housewife 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME John A. Warner Mary Elizabeth 15 WAS DECEASED EVER IN .. S. ARMED FORCES? 17 INFORMANT P.O. Box 599, Cumberland, Md. 21502 16. SOCIAL SECURITY NO (Yes, no, ar unknown) (If yes give wor or dates of service) Allegany County Infirmary records. cremation, 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the buriol-transit p IMMEDIATE CAUSE (o) Page 4 moy be retained by the haspital or attending physicion. TO FUNERAL DIRECTOR: After this certificate has been signed by DUE TO burio Conditions, if any, which gove rise to immediate couse (o). DUE TO os the prior to t stating the underlying couse lost WAS AUTOPS' PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) for use 3 should be detached for use with the State Dept. of Health NO 20o ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg , etc.) of work 21. I certify that (I) (this hospital) attended the deceased framto 9/11/67 19 that (I) (we) last saw the deceased alive an_ P • M. from couses and an the date stated above. and that death accurred at 22n SIGNATURE 22b. DATE SIGNED director, page 3 should be filed v DIRECTOR PHYS. 22c. PHYSICIAN'S 22d. ADDRESS John A. Memorial Hospital, Cumberland, Md. Topper, 23c. NAME OF CEMETERY OR CREMATORY BURIAL CREMATION 23d. LDCATION (City or Town) (Stote) VR A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11802 11815 requires that the death certificate be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH attending p≣ysician and completely filled in by the funera permit. Then please remoys-carban papers. Pages ¹ and b COUNTY Allegany o. STATE Mary land o. COUNTY Allegany MARYLAND c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL ond give negrest town)
Cumberland Cumberl and 1966 e IS RESIDENCE ON A FARM? d STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) 218 N. Centre Street Allegany County Infirmary YES NO A 4. DATE 3 NAME OF Middle Last Year DECEASED Leta Troll Ann DEATH September 19 67 event, (Type or print) IF JNDER 24 HRS IF UNDER 1 YEAR 8. DATE OF BIRTH S. SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED Months Dovs Hours White 9/26/1882 Female WIDOWED DIVORCED 11, BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT 10o USUA, OCCUPAT ON (Give kind of work done 10b. KIND OF BUSINESS OR COUNTRY? during most of working life, even if retired)
Housewife INDUSTRY Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME John Riley Margaret Mellott 17. INFORMANT P.O. Box 599, Cumberland, Md. 2150 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service Allegany County Infirmary records. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and ONSET AND DEATH buriol-transit PART I, DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) 4200 DUE TO Conditions, if ony, which gove rise to immediate cause (o), DUE TO stating the underlying couse by the haspital or attending as the IN FULLIRAL MINICTOR: After this certificate has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART, 1(o), WAS AUTOPS) PERFORMED? of Health r 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20f. (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year Hour o.m foctory, street, office bldg., etc.) Not While at work ot work 2). I certify that (I) (this haspital) attended the deceased from 9/211/1966, 19 to9/21/196719___, that (I) (we) last be retained saw the deceased alive an 9/21/1967 19 and that death accurred at P. M. from causes and an the date stated above. 22b. DATE SIGNED 22o. SIGNATURE STAFF PHYS. X 9/22/1967 DIRECTOR M.D. director, page 3 should be filed a 22c. PHYSICIAN'S John Topper, Memorial Hospital, Cumberland, Md. NAME (Type) 230 BURIAL, CREMATION -OF-CEMETERY OR CREMATORY 23d LOCATION (City or Town). DATE THEREOF (Stote) 250. REC'D BY REGISTRAR 25b. REGISTRAR'S' SIGNATURE VR A15 (4) 20 M 1/66



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11803 11816 CERTIFICATE OF DEATH The low requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o STATE Maryland b. COUNTY Allegany Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town)

Cumberland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 9/67 Cumberland d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e IS RESIDENC 902 Michigan Avenue Allegany County Infirmary NO TS ut with NAME OF Middle 4. DATE Year DECEASED OF September 19 67 Garrett R. Twigg (Type or print) S. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years IF LINDER 24 HRS 7. MARRIED **NEVER MARRIED** birthdoy) /17/1890 Hours Male White cremation, or removol, and in any WIDOWED X DIVORCED 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1) BIRTHPLACE (County & State, or foreign country) 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT INDUSTRY Maryland Retired: Farming Laborer-Orchard 14. MOTHER'S MAIDEN NAME Hamnah Goldsborrough Charles F. Twigg 17. INFORMANT P. O. Box 599. Cumberland, Md. 2150 15 WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service Allegany County Infirmary records. no INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (o) ONSET AND DEATH Page 4 may be retained by the hospital or ottending physician. **DUE TO** Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? MO 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20c TIME OF INJURY Month, Doy, Year 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. factory, street, office bldg , etc.) at work L TO FUNERAL DIRECTOR: After 21. I certify that (I) (this hospital) attended the deceased from 9/19/67 to 9/211/67, 19___, that (I) (we) last saw the deceased alive an 9/21:/67 and that death accurred at A. M. fram causes and an the date stated above. 220 SIGNATURE 1 22b. DATE SIGNED 9/25/1967 DIRECTOR 22C PHYSICIAN'S M. Simons. M. D. George Memorial Hospital. Cumberland. Md. NAME (Type) 23t NAME OF CEMETERY OR CREMATORY 230. BUR AL, CREMATION, 23b. DATE THEREOF 23d LOCATION (City or Town) REMOVAL (Specify)
Burial Near Oldtown . Md . Allegany Sept.26,1967 Wilson Cemetery 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 James F. Scarpelli, Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH



Dr 1 1	Item 20b Film 393 10-4-6 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	11804 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT. 1, 2, and 3 to m PM3 Poge Health of Stortment of Stortme	1 PtACE OF DEATH o. COUNTY Allegany MARYLAND D CTY OR TOWN (if outside corporate imits, write RURAL and give nearest fown) Cumberland d NAME OF HOSPITAL OR INSTITUTION (if not in hospitol, give street oddress) 2 USUAL RESIDENCE (Where deceosed lived, if institution Residence before odmission) 5 OSTATE Pennsylvania CITY OR TOWN (if outside corporate limits, write RURAL and give nearest fown) Rural - Atremas d. STREET ADDRESS d. STREET ADDRESS e IS RESIDENCE ON A FARM?
hn 24 hours after death. If in any event within 2 nours.	Memorial Hospital YES NO
ite should be executed with the word "pending" in perditor to the Chief Medical Exama burnol-transit permit. Fleciemation, or removal, and	ISABEC P. Vance Substitute Martha E. Habogast
L EXAMINER: Thi secute the certificate Page 4 should be for your files. R: Page 3 should be attended by the following the follow	PART II OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART 1(o) 19 WAS ALTOPSY PERFORMED? YES NO CONTRIBUTING 200 EXTERNAL CAUSE WAS PRIMARY DO OF CONTRIBUTING CAUSE OF DEATH Fell off porch at home 200 TIME OF ALLRY Month, Doy, Yeor 3:00 DESCRIBE HOW INJURY OCCURRED 200 PLACE OF INJURY (Home, form, foctory, street, office bldg, etc) While Not While of work Home 21. Learning that I took chorge af the remains described above, held an Autopsy Inspection Industry Inquiry Inquir
TO DEPUTY MEDICA necessory, please ex the funeral director. 5 may be retained to FUNERAL DIRECTO Health or its designed.	SIGNATURE SIGNAT



1	Div	ision of STATISTICAL	MARYLAND STATE D RESEARCH AND RECORDS, 3			AND 21201
FOR STATE	11805		MEDICAL EXAMINER'S			11818
deloy is Page HEALTH DELT	D CITY OR TOWN (FOL	LLEGANY	MARYLAND	o. STATE New	(Where deceased lived, if institut Jersey outside corporate limits, write RUF	Hudson .
Part Part afte	CUMBER d NAME OF HOSPITAL C	irside corporate limits, ie nedrest tawn) LAND DR INSTITUTION (If not in ho	DOA	Jersey d STREET ADDRESS		e IS RESIDENCE ON A FARM?
oges 1, th form	MEMORI.	MEMORIAL HOSPITAL 3 NAME OF First Middle			ennedy Blud.	AE2 NO K
offer dec 8. Give P olong with the	DECEASED (Type or pnnt)	Joseph	Gabriel ARRIED NEVER MARRIED [Valsh 8 DATE OF BIRTH	DEATH Sept	,
urs of in 18.		hite wio	OOWED DIVORCED 100 KIND OF BUSINESS OR	July 4, 194	Look buetheless)	Manths Days Haurs Min
thin 24 hours cent in them 18 miner's Office o	duing mast of working to	even if retired)	Construction	Jersey (City, N. J.	12 CITIZEN OF WHAT COUNTRY? S. A.
within pentil xomine ile pog	13 FATHER'S NAME Joseph			14. MOTHER'S MAIDEN Ruth Gal	Lvin	
ecuted ing" in edical Electrical	Unknown (If y	U S ARMED FORCES? The state of the state of service and service are service as the service are serviced as the service are service as the service are serviced as the serviced are serviced	16 SOCIAL SECURITY NO 17 148-32-9975 Re	informant outh Funera	Addre e Home 202 Old	
necessory, please execute the certificate, writing the word "pending" in penal in Item 18. Give Pages 1, the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retoined for your files. O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Der Health or its designated agent, prior to burial, cremation, or removal, and in any event within 7 hours.	1B CAUSE OF DEATH V	IMMEDIATE CAUSE (a)		SHED CHES	T	SULDENTH
should he wor to the (burial-t mation,	Conditions, if any, wh	use (a), (Due to	(AU	TOMOBILE	ACCIDENT)	
ithing that darked and as o	stoting the underlyin	g couse (c)	UTING TO DEATH BUT NOT RELATED TO	THE TERMSHA DISCARS S	OHDITION CRUEN IN DARK 1(-)	VOCATHIA DAW OF
his cer are, wi e forw be use to bur	NOTAL IN CAUGE S ONLY					19 WAS AUTOPSY PERFORMED? YES NO
AL EXAMINER: This execute the certificate, or Page 4 should be for your files. TOR: Page 3 should be undered agent, prior to for the page 1 should be undered ogent, prior to for the form of the for	200 EXTERNAL CAUSE PRIMARY OF CONTRI CAUSE OF DEATH 200 T ME OF NIURY 200 T ME OF NIURY	BUTING LI	20b DESCRIBE HOW INJURY OCCURRED Driver of veh	icle in o	ne car accid	
AL EXAMINER: execute the certion Page 4 should for your files. TOR: Page 3 should protect ogent, pri	20c TME OF NJURY 12:25 pmS	Month, Day, Year ept. 161967	20d INJURY OCCURRED 20e Pt While Not While at wark Rt	ACE OF INJURY (Home, factory, street office bidg , et 226 S. C.	rm, 20f (City or town) (c) f Pa.line.	(County) (State) Allegany, Md.
AL EXECUTION PAGE AND			he remains described above, t ses , Acadent XX Su	eld an Autapsy 🔲	, Inspection 🔣, Inqu	riry 🔯 and in my apinion
MEDT please direct retaine DIREC ts desu	ACTUAL SIGNATURE	Pone dici	4 11-	CHIEF MEDICA	AL EXAMINER EDICAL EXAMINER	22. DATE SIGNED
O DEPUTY MEDICA necessory, please ex the funeral director 5 may be retoined to 0 FUNERAL DIRECTO Health or its design	EXAMINER'S NAME (Type)	BENEDICT	SKITARELIC, M.	D DEPUTY MEDI	CAL EXAMINER 🔊 Sep eet, city town, or county)Cum	
To Dinece	230 BURIAL CREMATION REMOVAL (Spenty)	23b DATE THEREOF 9/19/67	230 NAME OF CEMETERY OF HOLY Cross (omotory	23d LOCATION (City of To-	ton Bergen, N. J.
VR A15ME (5)	24 FUNERAL DIRECTOR		ADDRESS Greene St. Cumber	Md. 25a REI	CD BY REGISTRAR 25b REP 2 0 1967	G STRAR'S SIGNATURE





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11807 058FF CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The taw requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, funstitution. Residence before admission) a. COUNTY o. STATE b. COUNTY iely filled in by the fun-ban papers. Pages 1 c , within 72 haurs after d ALLEGANY MARYLAND ALLEGANY b CITY OR TOWN (If autside corporate Hmits, write RURAL and give nearest town)

CUMBERLAND, MD c. LENGTH DE STAY IN 1b c CITY OR IDWN (If autside corporate limits, write RURAL and give nearest town) CUMBERLAND. MD DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RES DENC d STREET ADDRESS ON A FARM? MEMORIAL HOSPITAL CENTRE YES NO N carban 3. NAME OF Middle Firs* 4. DATE Day Year DECEASED DOLLIE V WIGFIELD 18 SEPT 67 event, (Type or print) DEATH 79 physician and compl hen please remave c naval and in any ever S SEX IF UNDER 24 HRS 6 COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years 7. MARRIED **NEVER MARRIED** last birthday) Months Days Haurs FEMALE WHITE TXI 9-17-96 WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work dane 10h KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? MD None

13. FATHER S NAME U.S.A. 14 MOTHER'S MAIDEN NAME ar remava KELLY STUMP MYRTLE HENKEL 15 WAS DECEASED EVER IN L.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, na, or unknown) (If yes give war ar dates of service) None MEMORIAL HOSPITAL CUMBERLAND . MD. 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b) and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) INTERVAL BETWEEN ONSET AND DEATH 4.201 DUE TO burial, Conditions, if any, which gave (b) nse to immediate cause (a), DUE TO r this certificate has been si detached for use as the b te Dept. af Health priar ta b stating the underlying cause TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the hospital ar attending last. (c) WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) be detached for use State Dept. of Health NO F 20a ACC, DENT WAS UNDERLYING □ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (City or tawn) (County) (State) MED Hour om factory, street, affice bldg, etc.) Nat While at wark at work 21. I certify that (1) (this happital) attended the deceased from 3 shavld l I with the S date stated above TO FUNERAL DIRECTOR: saw the deceased alive and death occurred from couses and the on 220 SIGNATURE MED. DIRECTOR STAFF director, page 3 should be filed v M.D 22d AODRESS 22c. PHYS CIAN'S **SCHINDLER** NAME (Type) DR CUMBERLAND. MD. 230 BURIAL CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) REMOVAL(Specify) 9/21/67 Sunset Memo. Pk. Burial Cumberland, Alleg. 2Sq. REC'D BY REGISTRAR 256 REGISTRAR S SIGNATURE 24 FUNERAL DIRECTOR ADDRESS 5 25M 1/67 Cumberland, Md. Philip B. Wendt



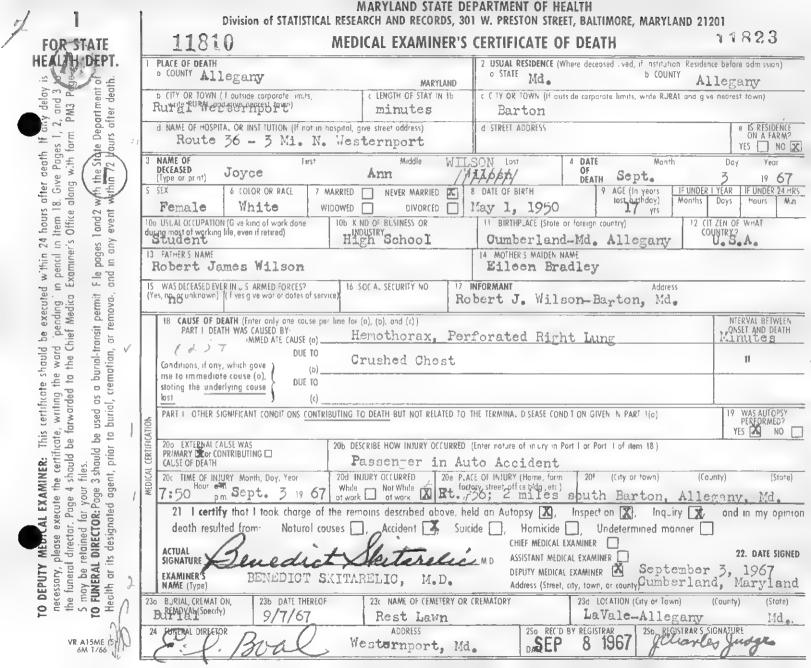
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11808 11821 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DERT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY ofter death If any delay is 8. Give Pages 1, 2, and 3 to along with form PM3. Page with the State Department of MARYLAND ALLEGANY ALLEGANY MARYLAND b CTY OR TOWN (If autside carparate limits, C. LENGTH OF STAY IN 16 c CITY OR TOWN (If guitside carparate limits, write RURAL and give negrest tawn) write RURAL and give nearest town) CUMBERLAND 40 YEARS CUMBERT, AND d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS ROUTE 1. VALLEY ROAD DOA MEMORIAL HOSPITAL This certificate should be executed within 24 hours ofter death cate, writing the word "pending" in pencil in Lem 18. Give Page NAME OF Lost 4 DATE Month Dov Year DECEASED SEPT. 19 67 WILFONG DEWEY G. 18 (Type or print) DEATH 8 DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS Jost birthday) Months MALE WHITE APRIL 26.1897 WIDOWED DIVORCED 11. BIRTHPLACE (State or foreign country) 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT FIBERS W. VA. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME e certificate, writing the word "pending" in penci should be farwarded to the Chief Medical Examin THOMAS WILFONG LAVERNE HOSTETTER 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, na, ar unknown) (If yes give war ar dates af service) RETTA H. WILFONG CUMBERLAND. MD. 220 10 2449 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY CORONARY OCCLUSION IMMEDIATE CAUSE (a) DUE TO CORONARY SCLEROSIS Canditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying couse 19 WAS AUTOPSY PERFORMED? PART I OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. DISEASE CONDITION GIVEN IN PART 1(d) removal. NO X 20g EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part II of item 18.) PRIMARY CONTRIBUTING CAUSE OF DEATH MEDICAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, 20c TIME OF INJURY Manth, Day, Year (City or town) (County) (State) factory, street, affice bldg, etc) Haur a.m at wark at work 21. I certify that I taak charge of the remains described above, held an Autopsy [], Inspection [X], Inquiry [X], and in my apinian death resulted from. Notural causes V. Homicide . Undetermined manner CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER SEPTEMBER 18
Address (Street, city, town, or counting tomber land, EXAMINER'S BENEDICT SKITARELIC, M.D. NAME (Type) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23g BURIAL CREMATION. SEPT.21,1967 CUMBERLAND, MD. ZION MEMORIAL PARK 2So. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATURE A15ME (5) BYRON KIGHT CUMBERLAND, MD.



	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
R STATE	11803 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
H DEPT	1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed wed, if institution Residence before admission)
	O. COUNTY ALLEGANY MARYLAND O. STATE D. COUNTY ALLEGANY ALLEGANY
9	b CTY OR TOWN (if outside corporate limits to LENGTH OF STAY N Ib to CTTY OR TOWN (if outside corporate limits write RURAL and a veneous) town
	RFD 2 FLINTSTONE, MD. 6yrs. RFD 2 FLINTSTONE, MD.
	d NAME OF HOSPITA, OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS e IS RESIDENCE
^^	WILLIAMS ROAD WILLIAMS ROAD YES X NO X
1	2 NAME OF First Middle Lost 4. DATE Month Doy Year
	(Type of print) HARRIET T. WITSON DEATH SEPT. 1), 1967
	SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH 9 AGE (In years FUNDER LYEAR IF UNDER 74 HRS
1	FEMALE WHITE WIDOWED DIVORCED FEB.15.1873 Ost birthdoy) Months Doys Hours M.n
,	100 US., AL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHP, ACE (State or foreign country) 12, CTIZEN OF WHAT
	during most of wasting life even if retired) HOUSEWIFE (COUNTRY? USA)
	13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME
	THOMAS J. WILSON ELIZABETH "ROBINETTE" WILSON
	The state of the s
	(Yes, no, acural nown) (If yes give wor or dotes of service) 217-54-6296 WAS DECEASED EVER IN 3 ARMED FORCES? (16 SOC A. SECURITY NO INFORMANT Address MR FRED WILSON RFD 2 FILINTS TONE, MD.
	18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. CORONARY OCCLUSION INTERVAL BETWEEN DASE AND DEATH SUBJECT OF DEATH (Enter only one couse per line for (a), (b), and (c).)
	IMMEDIATE CAUSE (o)
	COROLLA TELEVISION OF THE CORT
	rise to immediate couse (a), (IV)
	stoting the underlying couse
	Dest. Graph Part Other significant conditions contributing to death but not related to the terminal disease condition given in part 1(a) 19 WAS AUTOPSY
)	FARE TO THE RESIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(b) PERFORMED?
Į,	YES NO K 200 DESCRIBE HOW INJURY OCCURRED (Enter noture of nurry in Port Lor Port Lof Item 18.)
	PRIMARY Or CONTRIBUTING
	PERFORMED? YES NO X 200 EXTERNAL CALSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH 201 TIME OF INJURY Month, Doy, Year Hour a.m. 202 INJURY OCCURRED OF INJURY (Home, farm, Hour a.m.) 203 INJURY OCCURRED OF INJURY (Home, farm, Hour a.m.) (County) (State)
	20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, Hour a.m. 20f (City or town) (County) (State)
	p.m 19 of work LJ of work LJ
	21. I certify that I took charge of the remains described above, held on Autopsy, Inspection
	deoth resulted from: Notural couses 🕵, Accident 🗌, Suicide 🔲, Hamicide 🔲, Undetermined manner 🗍
	ACTUAL
	SIGNATURE ASSIANT MEDICAL EXAMINER L
1	EXAMINER'S DEPUTY MEDICAL EXAMINER X SEPTEMBER 13, 1967
	NAME (Type) BENEDICT SKITARELIC M.D. Address (Street, city, town, or OND) BERLAND MARYLANI
	230 BUR AL (REMATION, REMOVAL (Specify) BURLLAL 230 DATE THEREOF 231 DATE THEREOF 231 DATE THEREOF 232 NAME OF CEMETERY OR CREMATORY FLINTSTONE, MD. ALLEGANY MD.
	24 C NUCHAI DIDECTOR 1 2Ch DECKEDAD C & CA APRILL
)	
	H. LEE SILCOX 404 DECATUR ST. CUMBERLAND, MD. DASEP 2 0 1961

MARYLAND STATE DEPARTMENT OF HEALTH

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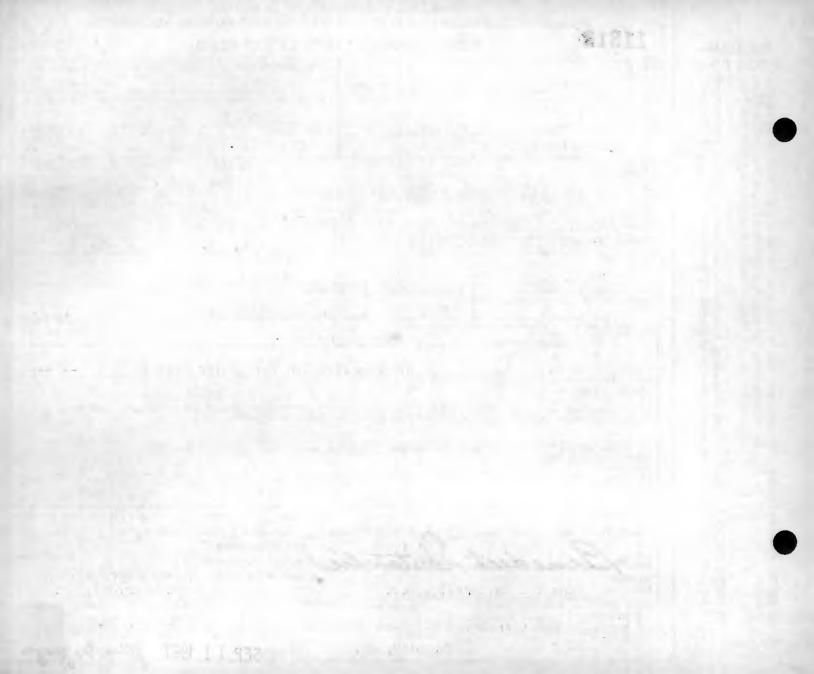
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11812 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11825 DEP PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a COUNTY a. STATE Page **b** COUNTY ALIEGANY 0 of death. MARYLAND and 3 1 b (ITY OR TOWN (If outside carparate I mits, write RURAL and give nearest fawn)

FROSTBURG c. LENGTH DE STAY IN IN c CITY OR TOWN (If guitside carparate in its write RURAL and give negrest tawn) offer LIFE FROSTBURG d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENC tate Deg Give Pages 1, ON A FARM? 144 GREEN STREET 144 GREEN NO TH ofter death 3 NAME OF First Midd e Last DATE Day DECEASED MARY YATES SE PURMERER 19. 19 67 (Type or print) DEATH MIL S SEX 6 COLOR OR RACE B DATE OF BIRTH AGE (In years IF UNDER | YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED last birthday) Days Haurs in Item 18. MIDOWED FEMALE WHITE DIVORCED 24 hours 10a JSUAL OCCUPAT ON (Give kind of work done 10b K ND OF BUSINESS OR 1) BRTHPLACE (State or tareian country) 12 CITIZEN OF WHAT E during most of working life, even if retired) INDUSTRY U. S. A. MARYLAND RETIRED-TEXTILE DEPT CELANESE CORP pencil 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within _ LOUIS RANK ELIZABETH JENKINS 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address permit. ar removol, (Yes, na, or unknown) (If yes give war or dates of service) 214-28-6979 HENRY YATES, FROSTBURG, MD. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY CONSET AND DEATH celusioni IMMEDIATE CAUSE (6) This certificate should writing the word cremotian, DHE TO Conditions, if any, which gave rise to immediate couse (a). DUE TO stating the underlying couse last PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. DISEASE CONDITION GIVEN IN PART I(d) 19 WAS AUTOPSY PERFORMED? YES 🗆 NO S 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) PRIMARY OF CONTRIBUTING FILE EXAMINER: CAUSE OF DEATH. MEDICAL 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, form, (City or town) (County) (State) factory, street, office bldg., etc.) Not While at work at work 21. I certify that I taak charge of the remains described above, held an Autapsy Inspection X. Inquiry X ond in my apinion death resulted fram: Natural couses Accident | Suicide . Hamicide | Undetermined manner CHIEF MEDICAL EXAMINER | ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE 3 O DEPUTY 9/19/67 DEPUTY MEDICAL EXAMINER **EXAMINER'S** Heolth BENEDICT SKITARELIC. M. D. Address (Street, city town, or county) RD 9 CUMBERLAND. MD. NAME (Type) 23o BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 500 BURIAL (Specify) FBG. MEMORIAL PARK FROSTBURG. MD. 25b. REGISTRAR'S SIGNATURE DURST, SR., FROSTBURG, 2Sa. REC'D BY REGISTRAR VR A15ME

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11813 11826 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEP PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE and 3 to M3. Page b. COUNTY ALLEGANY MARYLAND MARYLAND ALLEGANY delay b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lawn) c. LENGTH OF STAY IN 15 35 YEARS CUMBERLAND CUMBERLAND d. NAME OF HOSPITAL OR INSTITUTION (II not in hospital, give street address) d. STREET ADDRESS B. IS RESIDENCE farm ON A FARM? SACRED HEART HOSPITAL 813 BRADDOCK ROAD in Item 18. Give Pages YES | NO PX 24 haurs after death. Office alang with 3. NAME OF Middle 4. DATE First Lost Month Year DECEASED DOROTHY YOUNG R. SEPT. 67 (Type or print) DEATH 4 19 with t IF UNDER 1 YEAR S. SEX 9. AGE (In years IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH lost birthdoy)
58 yrs Manths Hours WIDOWED X pages land2 v FEMALE WHITE DIVORCED JULY 29,1909 10o. USUAL OCCUPATION [Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) HOUSEW LFE COUNTRY? KITZMILLER, MD. pencil 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME lie executed within GR IMM ROY O. RAFTER MARGARET and 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) or remayal. CUMBERLAND, MD. NONE MRS. GAIL GOLLADAY 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: CEREBRAL HEMORRHAGE IMMEDIATE CAUSE (o)_ ward This certificate shauld used as a burial-tri burial, crematian, DUE TO Hypertensive Cardiovascular Disease Canditions, if any, which gove rise to immediate couse (a). DUE TO stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO X YES p 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) PRIMARY Or CONTRIBUTING CAUSE OF DEATH (City or town) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) may be retained far your FUNERAL DIRECTOR: Page Not While of work 21. I certify that I taak charge of the remains described above, held an Autapsy [], Inspection [X], Inquiry X, and in my apinian the funeral directar. Accident death resulted fram: Natural causes X. Suicide | Hamicide | Undetermined manner CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATO DEPUTY MEDICAL EXAMINER X September 4, 1967 EXAMINER'S 5 may b Address (Street, city, town, or county)Cumber land, Md. Benedict Skitarelic, M.D. NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 23o. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL CUMBERLAND, MD. SEPT. 7,1967 ROSE HILL CEMETERY 25b. REGISTRAR S SIGNATURE 24. FUNERAL DIRECTOR 25o. REC'D BY REGISTRAR BYRON KIGHT VR A15ME (5) CUMBERLAND, MD. Mianles Judg 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11814 11827 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY n STATE b. COLINTY 3 to Page ALLEGANY MARYLAND PENNSYLVANTA BLATE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) deloy b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town)
CUMBERLAND D.O.A. HOLLIDAYSBURG d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE Give Pages 1, D.O.A. MEMORIAL HOSPITAL 520 CLARK STREET NOT YES along with NAME OF First Middle DATE Lost Month Year DECEASED S. (Type or print) JAMES ZEEK DEATH SEPT 18 19 67 IF UNDER 24 HRS IF UNDER 1 YEAR SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years last birthdoy) Months Dovs in Item 18. WHITE MALE death. WIDOWED DIVORCED 24 hours Office 10o. USUAL OCCUPATION (Give kind of work done IDE KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired)
BOTLER WORKER INDUSTRY COUNTRY? ofter writing the word "pending" in pencil in rwarded to the Chief Medical Examiner's BOTTER pages HOLLTDAYSBURG II.S A be executed within 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME hours ANNA UST NGERU ZEEK WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, po or Unknown) (If yes give wor or dates of service) within 211-07-1291 JAMES ZEEK JR. DUCANSVILLE PA RFD#2 IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN event Sudden DEATH CORONARY OCCLUSION, LEFT IMMEDIATE CAUSE (o) This certificate should DUE TO CORONARY Conditions, if any, which gove THROMBOSIS. LEFT rise to immediate couse (a). = DHE TO stating the underlying couse CORONARY SCLEROSIS. MARKED SD WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) removol, YES IX NO 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 1B.) 3 should PRIMARY CONTRIBUTING cremotion, or EXAMINER: CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) (actory, street, office bldg., etc.) Not While ot work ot work 21. I certify that I took charge of the remains described above, held on Autapsy XI. Inspection ... Inquiry X. ond in my apinion death resulted fram: Natural causes X Accident Suicide . Hamicide Undetermined manner CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior FUNERAL DEPUTY MEDICAL EXAMINER September 18, 1967 BENEDICT SKITARELIC, M.D. Health p Address (Street, city, town, or countQUMBERIAND. MARYTAND NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 230. BURIAL, CREMATION, 23d LOCATION (City or Town) (County) 21,1967 PRESBYTERIAN CEMETERY CRY HOLLTDAYSBURG BL.
250. REC'D BY REGISTRAR'S ST 24. FUNERAL DIRECTOR VR A15ME (5) H. LEE SILCOX LOL DECATUR STREET CUMBERLAND 6M 1/67 MARYLAND

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The Table of the Park